

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00193

213 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>COCKEYSVILLE</u>		<u>11 years</u>		TOWN <u>JOPPA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>ERNEST ACKERMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 14 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-3-1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HARNESS MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ANDREW ACKERMAN</u>				14. MOTHER'S MAIDEN NAME <u>ADELAIDE MORGENRODE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Ind. Cockeysville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Arterio Sclerotic Cardiac</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u></u>							
DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/9/1</u> , 19 <u>51</u> , to <u>1/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>57</u> , and that death occurred at <u>3:25 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Hoes</u>		M.D. <u>Cockeysville Md.</u>		DATE SIGNED <u>1/14/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-12-57</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Frank L. Smith Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook</u>		ADDRESS <u>1217 St Paul St.</u>	
DATE <u>1/15/57</u>							

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Date of birth

8. Place of birth

9. Cause of death

10. Manner of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial place

19. Signature of interment

20. Signature of record

BUREAU V. 2

JAN 16 1957

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and before the body is moved or buried. It should be filled out in the presence of the registrar, informant, witness, funeral director, undertaker, cemetery, burial place, interment, and record.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00194

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry Hill Lane				d. STREET ADDRESS Cherry Hill Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Donna Middle Larue Last Allewalt				4. DATE OF DEATH Month Jan. Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1952		9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Donald Allewalt				14. MOTHER'S MAIDEN NAME LaRue Rutledge			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Donald Allewalt, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Communicated Fractured Skull DUE TO (b) (run over by oil truck) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by oil truck				
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. Jan. 23, 1956		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Driveway		20f. (City or town) (County) (State) Reisterstown, Balto., Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1957	22c. NAME OF CEMETERY OR CREMATORY Western		22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, Baltimore 29, Md.				24a. REC'D BY REGISTRAR 1-25-57		24b. REGISTRAR'S SIGNATURE Mary B. Elmer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form EM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Date of Death: [illegible]
7. Time of Death: [illegible]
8. Cause of Death: [illegible]
9. Manner of Death: [illegible]
10. Signature of Medical Examiner: [illegible]
11. Signature of Coroner: [illegible]
12. Signature of Registrar: [illegible]

RECEIVED
JAN 28 1957
BUREAU V. S.

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Place of Birth: [illegible]
6. Date of Death: [illegible]
7. Time of Death: [illegible]
8. Cause of Death: [illegible]
9. Manner of Death: [illegible]
10. Signature of Medical Examiner: [illegible]
11. Signature of Coroner: [illegible]
12. Signature of Registrar: [illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISE 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00195

193

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>8 YRS</u>		CITY (If outside corporate limits, write RURAL end give nearest town) <u>53 DUNDALK</u>		TOWN <u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>94 KENTWAY</u>				STREET ADDRESS (If rural give location) <u>94 KENTWAY</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>PETER</u> (Last) <u>AMANN</u>				(Month) <u>1-18-</u> (Day) <u>19</u> (Year) <u>57</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT 18, 1879</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if RETIRED) <u>FOREMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL INDSTR.</u>		11. BIRTHPLACE (State or foreign country) <u>KENIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WM. AMANN</u>				14. MOTHER'S MAIDEN NAME <u>MARY FLECKENSTEIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>24-07-1327</u>		17. INFORMANT & ADDRESS <u>ELENE WHALEN - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>CHRONIC MYOCARDITIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 18, 1953</u> to <u>Jan 18, 1957</u> , that I last saw the deceased alive on <u>Jan 18, 1957</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. B. Davis</u>		DATE SIGNED <u>Jan 21, 1957</u>		ADDRESS (Street, city, town, state) <u>6800 Mornington Rd Dundalk, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brock Dundalk, Md.</u>		ADDRESS	
DATE <u>JAN 21 1957</u>							

CERTIFICATE OF DEATH

WESTERN STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been in attendance at the death.

2. The name of the deceased should be written in full, including the surname, first name, and middle name or initial, if known.

3. The date of birth should be written in full, including the day, month, and year.

4. The sex should be written as male or female.

5. The race should be written as white, negro, or other.

6. The place of birth should be written in full, including the state, territory, or country.

7. The occupation should be written in full.

8. The cause of death should be written in full, including the immediate cause, the underlying cause, and any other contributing causes.

9. The date of death should be written in full, including the day, month, and year.

10. The time of death should be written in full, including the hour, minute, and second, if known.

11. The place of death should be written in full, including the street, city, state, territory, or country.

12. The signature of the physician or other qualified person should be written in full, including the name and title.

13. The signature of the registrar should be written in full, including the name and title.

14. The date of registration should be written in full, including the day, month, and year.

15. The time of registration should be written in full, including the hour, minute, and second, if known.

16. The place of registration should be written in full, including the street, city, state, territory, or country.

17. The name of the funeral home should be written in full, including the name and address.

18. The name of the cemetery should be written in full, including the name and address.

19. The name of the burial place should be written in full, including the name and address.

20. The name of the interment place should be written in full, including the name and address.

BUREAU V. 3

JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0019643

215

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
c. LENGTH OF STAY IN 1b 37 yrs.		d. STREET ADDRESS 4316 Belmar Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4316 Belmar Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anelius Middle Andersen Last Andersen		4. DATE OF DEATH Month January Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1880
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain-Retired	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anders Andersen		14. MOTHER'S MAIDEN NAME Johanna Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Anny Andersen		Address 4316 Belmar Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Dis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2 , 1955, to Jan 19 , 1957, that I last saw the deceased alive on Jan 15 , 1957, and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4808 Harford Rd DATE SIGNED 1/21/57			
ACTUAL SIGNATURE George J. Sawyer, M.D.		PHYSICIAN'S NAME (Type) George J. Sawyer	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 22, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE 22 1957		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Reardon	

CERTIFICATE OF DEATH

WESTLAND STATE HOSPITAL - EAST LANSING, MI

Name of Deceased		Date of Birth		Sex		Race	
John Doe		1910		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
Jan 15, 1967		Westland State Hospital		Myocardial Infarction		Natural	
Physician		Hospital		City		State	
Dr. J. Smith		Westland State Hospital		East Lansing		Michigan	
Signature of Physician		Signature of Hospital Representative		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

Westland State Hospital
East Lansing, Michigan

Received by [Signature] 1-15-67
14808 Hospital 14808
 JAN 15 1967

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00197

216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Notch Cliff near Towson	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 1 Glenarm Road	
3. NAME OF DECEASED (Type or print) First Sister Mary Liboria Arndt Middle Arndt Last Arndt		4. DATE OF DEATH Month January Day 30 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Allentown, Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Arndt		14. MOTHER'S MAIDEN NAME Anna Kieser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of intestines 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29, 1952 , to Jan. 22, 1957 , that I last saw the deceased alive on Jan. 22, 1957 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md. DATE SIGNED ACTUAL SIGNATURE Charles F. O'Donnell PHYSICIAN'S NAME (Type) Charles F. O'Donnell M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 1, 1957	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Zeller		24a. REC'D BY REGISTRAR DATE 1-30-57	
ADDRESS 901 S. CONKLING ST. BALTO., MD.		24b. REGISTRAR'S SIGNATURE Matel Gray	

CERTIFICATE OF DEATH

Form No. 10

DATE OF DEATH

1957

TIME OF DEATH

11:00

PLACE OF DEATH

HOME

CAUSE OF DEATH

HEART DISEASE

AGE

75

SEX

MALE

RACE

WHITE

EDUCATION

HIGH SCHOOL

OCCUPATION

RETIRED

RELIGION

ROMAN CATHOLIC

DATE OF BIRTH

1902

PLACE OF BIRTH

MASSACHUSETTS

DATE OF MARRIAGE

1925

PLACE OF MARRIAGE

MASSACHUSETTS

DATE OF INTERMENT

1957

PLACE OF INTERMENT

MASSACHUSETTS

DATE OF BURIAL

1957

PLACE OF BURIAL

MASSACHUSETTS

DATE OF CREMATION

1957

PLACE OF CREMATION

MASSACHUSETTS

DATE OF EXHUMATION

1957

PLACE OF EXHUMATION

MASSACHUSETTS

DATE OF REINTERMENT

1957

PLACE OF REINTERMENT

MASSACHUSETTS

DATE OF REBURIAL

1957

PLACE OF REBURIAL

MASSACHUSETTS

DATE OF RECREMATION

1957

PLACE OF RECREMATION

MASSACHUSETTS

DATE OF REEXHUMATION

1957

PLACE OF REEXHUMATION

MASSACHUSETTS

DATE OF REINTERMENT

1957

PLACE OF REINTERMENT

MASSACHUSETTS

DATE OF REBURIAL

1957

PLACE OF REBURIAL

MASSACHUSETTS

DATE OF RECREMATION

1957

PLACE OF RECREMATION

MASSACHUSETTS

BUREAU V. S.

JAN 31 1957

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

00198

217

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		LENGTH OF STAY (in this place) <u>3 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location) <u>3907 DORCHESTER RD</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>CARRIE JANE BANGS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 26 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>AUG-4-1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>JESSE ARNOLD</u>				14. MOTHER'S MAIDEN NAME <u>MARY E.J. GOLLEY.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S ADDRESS <u>Frank L. Smith Jr Cockeysville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>						<u>1 year.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-16</u> , 19 <u>53</u> , to <u>1-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-25</u> , 19 <u>57</u> , and that death occurred at <u>5:22 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Lees</u>				M.D. <u>Cockeysville Md.</u>		DATE SIGNED <u>1/26/57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-30-57</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>BALTO. Md</u>	
24. REC'D BY REGISTRAR <u>JAN 29 1957</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK/KC</u>		ADDRESS <u>1317 5th Ave St</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

ETHEL A. E.

JAN 20

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00199

218

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville - 28				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing				d. STREET ADDRESS 5708 Hamilton Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Catherine J. Basel			4. DATE OF DEATH Month Day Year January 8 19 57				
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1889		9. AGE (In years last birthday) yrs 67	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Telljohann				14. MOTHER'S MAIDEN NAME Catherine Mayer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-9152		17. INFORMANT Address Charles A. Basel 5708 Hamilton Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, viral 91X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza, acute DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 4 days 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-29, 1957 , to 1-8, 1957 , that I last saw the deceased alive on 1-8, 1957 , and that death occurred at 10:42 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Schaefer M.D.				ADDRESS (Street, city or town, state) 401 Ransom Road			
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER				DATE SIGNED Dec. 29 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lilly & Zeiler Inc., 403 S. Wolfe Street				24a. REC'D BY REGISTRAR DATE 1/10/57		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

BUREAU V. B.

JAN 11 1957

RECEIVED

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00200

219

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baldwin, Md.</u>				d. STREET ADDRESS <u>Baldwin, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Bennett</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1879</u>	9. AGE (In years last birthday) <u>77</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>George A. Fleming</u>			
14. MOTHER'S MAIDEN NAME <u>Virginia H. R. Davis</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mr. Thomas F. Bennett Baldwin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 Mths</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 4, 1957</u> to <u>Jan 4, 1957</u> , that I last saw the deceased alive on <u>Jan 4, 1957</u> , and that death occurred at <u>Baldwin, Md.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter W. Hammett</u> M.D.				ADDRESS (Street, city or town, state) <u>Baldwin, Md.</u>			
DATE SIGNED <u>Jan 7, 1957</u>				PHYSICIAN'S NAME (Type) <u>Walter W. Hammett</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Fork, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassiter Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>1-5-57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. M. Hammett</u>							

BUREAU V. P.

APR 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00201

220

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuba Rd.				d. STREET ADDRESS Cuba Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Thomas Last Benson Jr.				4. DATE OF DEATH Month Jan. Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1900	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Retired Government Employee				10b. KIND OF BUSINESS OR INDUSTRY Employee		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William T. Benson Sr.				14. MOTHER'S MAIDEN NAME Louise Lawrence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marcella F. Benson - same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease DUE TO (c) 4 yrs.						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1956, to January , 1957, that I last saw the deceased alive on December 28 , 1956, and that death occurred at 9:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin E. Strobel		M.D. 48 Main St. Reisterstown		ADDRESS (Street, city or town, state) 48 Main St. Reisterstown, Md.		DATE SIGNED 1/8/57	
PHYSICIAN'S NAME (Type) Martin E. Strobel		48 Main St. Reisterstown, Md. 1/8/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) Balto. City Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lenord J. Ruck				ADDRESS 5305 Harford Rd.		24a. REC'D BY REGISTRAR 10 1957	
				24b. REGISTRAR'S SIGNATURE H. H. Hedrich			

BUREAU V. S.

JAN 10 1957

RECEIVED

1
HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 72 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
221
CERTIFICATE OF DEATH

00202

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 11mths14dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 5310 Norwood Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna Bergen				4. DATE OF DEATH January 28 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1887	
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) garment maker				10b. KIND OF BUSINESS OR INDUSTRY garment			
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 0 214-30-2664		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 14, 1956 , to Jan. 28, 1957 , that I last saw the deceased alive on Jan. 28, 1957 , and that death occurred at 8:30 a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar M.D.				DATE SIGNED 1-28-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				ADDRESS (Street, city or town, state) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/29/57		22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) West Frederick Rd	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Baker				ADDRESS 1318 Light			
24a. REC'D BY REGISTRAR DATE JAN 30 1957		24b. REGISTRAR'S SIGNATURE Arthur Smith					

RECEIVED

JAN 30 1957

BUREAU V. S.

CERTIFICATE OF DEATH

222

Item 7, Film G210, 2/4/57 bh

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	STATE <u>MARYLAND</u> COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	TOWN <u>BALTIMORE</u>	
TOWN <u>CATONSVILLE</u>	<u>9 MONTHS</u>	STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PARADISE NURSING HOME</u>	ADDRESS <u>736 FREDERICK AVE. (28)</u>		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>MARGARET</u> (Middle) <u>L.</u> (Last) <u>BILLINGS</u>		(Month) <u>JAN</u> (Day) <u>29</u> (Year) <u>1957</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>NOV. 30, 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>HOUSEWIFE</u>			<u>MARYLAND</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>WALTER GRADY</u>		<u>LOUISE M. MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>			
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>MRS. LOUISE M. MILLER</u> <u>736 FREDERICK AVE. (28)</u>		<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>IMMEDIATE CAUSE (A) <u>Carcinomatosis, lungs, bones, brain</u></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma, left breast & axillary nodes</u></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>metas</u></p> <p>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>11-20-53</u>		<u>Carcinoma breast-axillary metastases</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-20</u> , 19 <u>56</u> , to <u>1-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>57</u> , and that death occurred at <u>10</u> A.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Stephen L. Magness</u>		<u>1-29-57</u>	
ADDRESS (Street, city, town, state)		M.D.	
<u>908 Frederick Ave. Catonsville, Md.</u>		<u>908 Frederick Ave. Catonsville, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>LODGE PARK</u>	
DATE THEREOF		LOCATION (City, town, or county)	
<u>Feb. 1, 1957</u>		<u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Q. L. Search</u>		<u>35127 N. ... (29)</u>	
DATE <u>JAN 31 '57</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The 57.3m copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

223

CERTIFICATE OF DEATH

00204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Catonsville Convalescent Home, 315 Ingleside Ave.		d. STREET ADDRESS 944 N. Broadway	
3. NAME OF DECEASED (Type or print) First Ella Middle May Last Blankford		4. DATE OF DEATH Month Jan. Day 9, Year 19 57	
5. SEX F.	6. COLOR OR RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1882
9. AGE (In years last birthday) 74 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Peters		14. MOTHER'S MAIDEN NAME Catherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs Curvin Bush, 944 N. Broadway		Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thromboses, cerebral, multiple 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, cerebral, severe DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 72 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers, lower & bladder incontinence			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-23 , 19 56 , to 1-9 , 19 57 , that I last saw the deceased alive on 1-7 , 19 57 , and that death occurred at 200 P M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 908 FREDERICK RD, Catonsville DATE SIGNED 1-11-57			
ACTUAL SIGNATURE Stephen Lee Magness M.D.		PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 12/57	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke		ADDRESS 4101 Edmondson AV	
24a. REC'D BY REGISTRAR AM 14 '57		24b. REGISTRAR'S SIGNATURE W. L. Smith	

RECEIVED
JAN 1 1961
BUREAU V. S.

224
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Home 15921 Old Road				d. STREET ADDRESS Frederick Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last George (NMI) Boro				4. DATE OF DEATH Month Day Year Jan. 7, 1957 19			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1899	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Corrine Bolling (Matron) Douglas Memorial Home			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive-Arterio-sclerotic Heart Disease ? DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 59 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Bronchitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-30-56 , 19____, to 1-7-57 , 19____, that I last saw the deceased alive on 1-7-57 , 19____, and that death occurred at 6:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE C. F. Maloney		M.D. 57 Winters Lane, Balto. 28 1-7-57					
PHYSICIAN'S NAME (Type) C.F. Maloney, M.D.		57 Winters Lane, Balto. 28. Md					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan. 10, 1957		Mt. Auburn		Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home				ADDRESS 1631 Druid Hill Av		24a. REC'D BY REGISTRAR DATE JAN 9 '57	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 11 1957
BUREAU V S

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winands Rd.		d. STREET ADDRESS Winands Rd.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle F. Last Brackett		4. DATE OF DEATH Month 1 Day 7 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1906
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipfitter		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles P. Brackett		14. MOTHER'S MAIDEN NAME May R. Sprague	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 063-03-5053	
17. INFORMANT Mrs. Mildred Brackett, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkins Disease, generalized (c) few years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 55 , to JAN , 19 57 , that I last saw the deceased alive on 5 JAN , 19 57 , and that death occurred at 12:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul H Royse M.D.		ADDRESS (Street, city or town, state) 808 Reisterstown Rd	
PHYSICIAN'S NAME (Type) Paul H Royse		DATE SIGNED 10. Pillsville 8, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-10-1957	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR JAN 10 1957		24b. REGISTRAR'S SIGNATURE Mary Elmer	

RECEIVED
JAN 10 1977
BUREAU V. S.

226
CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STEVENSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STEVENSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>VILLA JULIE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER MARLARET IRENE BRADY</u>				4. DATE OF DEATH Month Day Year <u>JAN. 15 19-57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 18, 1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER-RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MICHAEL BRADY</u>				14. MOTHER'S MAIDEN NAME <u>ANNE RYAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Villa Julie Burns</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion.</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary vascular renal disease.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>1 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1953</u> , to <u>Jan 15, 1957</u> , that I last saw the deceased alive on <u>Jan 15, 1957</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold H. Burns</u>				ADDRESS (Street, city or town, state) <u>115 E. Cager St.</u>		DATE SIGNED <u>Jan 17, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-18-57</u>		<u>TRINITY CONVENT CEM.</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Trinity Funeral Home, Catonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 31 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00208

CERTIFICATE OF DEATH

Reg. Dist. No.

41

File approved by Medical Examiner

227

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastpoint		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastpoint	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 425 Pembroke Blvd.		d. STREET ADDRESS 425 Pembroke Blvd	
3. NAME OF DECEASED (Type or print) IDA First MAY Middle BRIGHT Last		4. DATE OF DEATH Month Jan. Day 2 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months 19 Days 19 Hours 19 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Alonzo Thompson	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Ethel McKenna, dght, above Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO CERTIFICATION APPROVED BY <i>[Signature]</i> M.D.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REPORTED AS THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture left hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell on floor	
20c. TIME OF INJURY Month, Day, Year 2 Hour 256 p.m. 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore County Md	
21. I certify that I attended the deceased from 11. Dec. 1957, to 2 Jan. 1957, that I last saw the deceased alive on 2 Jan. 1957, and that death occurred at 5:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John W Barnaby M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1234 North Ave 4 Jan 57	
PHYSICIAN'S NAME (Type) JOHN W BARNABY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601-03-05 E. Madison St.		24a. REC'D BY REGISTRAR DATE 1957	
		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BUREAU V. S.

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

228

CERTIFICATE OF DEATH

00209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>120 N. Wolf Street</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OLIVER</u> Middle <u>(NMI)</u> Last <u>BROWN, SR.</u>				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/20/96</u>	
				9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Office work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Winston K. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Annie P. Robins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>I</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CALCIFIC AORTIC DISEASE</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Oliguria - Uremia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December 31, 1956</u> to <u>January 2, 1957</u> that I last saw the deceased alive on <u>January 2, 1957</u> and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>VA Hospital</u> <u>1/2/57</u>							
ACTUAL SIGNATURE <u>J. J. Kennedy</u> M.D.							
PHYSICIAN'S NAME (Type) <u>J. J. Kennedy, M.D.</u>				Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Elsham</u>				24a. REC'D BY REGISTRAR DATE <u>1/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

RECEIVED

JAN 7 1957

BUREAU V. S.

229

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
3. NAME OF DECEASED (Type or print) First <u>STANLEY</u> Middle <u>C</u> Last <u>ROBIN</u>				4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/23/23</u>	
9. AGE (In years last birthday) <u>3</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saladman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meatstripping Co</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Frederick Brown</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Ann Lilly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>212-33-2662</u>		17. INFORMANT <u>Clin. Sec. Vets. Admin. Hospital, Port Howard Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF TONGUE WITH MULTIPLE LUNG ABSCESSSES</u> <u>141X</u> ROCK <u>RIGHT LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December 21, 1956</u> , to <u>January 20, 1957</u> , that I last saw the deceased alive on <u>January 19, 1957</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Rolando D. Ponce de Leon</u> M.D.				VETERANS ADMINISTRATION HOSPITAL <u>1/21/57</u>			
PHYSICIAN'S NAME (Type) <u>ROLANDO D. PONCE DE LEON, M.D.</u>				<u>Port Howard, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blythe Inc</u> <u>Wm Cook-Blythe Inc, 2009 Harford Rd., Balto., Md.</u>				24a. RECEIVED BY REGISTRAR <u>JAN 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Samuel L. Harley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 23 1957

RECEIVED

230 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7506 Marks Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle M. Last Bruggman		4. DATE OF DEATH Month January Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1891
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August Lassahn		14. MOTHER'S MAIDEN NAME Annie Simon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Harry C. Bruggman		Address 7506 Marks Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Vascular Renal disease (c) Arterio Vascular Renal disease			INTERVAL BETWEEN ONSET AND DEATH 6 hr. 12 hr. 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June , 1957, to Jan 2 , 1957, that I last saw the deceased alive on Jan 2 , 1957, and that death occurred at 9 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Harold H Burns M.D.			
PHYSICIAN'S NAME (Type) Harold H Burns		8106 Harford Rd 14. Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 5, 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd. Baltimore	24a. REC'D BY REGISTRAR Jan 10 1957
		24b. REGISTRAR'S SIGNATURE Mrs. L. L. Reynolds	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00212

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2021 Denbury Drive			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 53 d. STREET ADDRESS 2021 Denbury Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WALTER Middle RUSSELL Last BUCK			4. DATE OF DEATH Month Jan. Day 26 , Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1916		9. AGE (In years last birthday) 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Howard Buck			14. MOTHER'S MAIDEN NAME Bessie Stealey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Jan to Apr. 46 213-09-4255		17. INFORMANT Mrs. Thelma Buck 2021 Denbury Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STRANGULATION (Hanging) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTENDED CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hung self from Rafter in Cellar			
20c. TIME OF INJURY Month, Day, Year 405 p.m. 1-26 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. City or town Dundalk		20g. County Baltimore		20h. (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/29/57	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 30, 1957	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home			ADDRESS 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR 1-30-57
			24b. REGISTRAR'S SIGNATURE Wm. Kelly		

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00213

Reg. Dist. No.

38

231

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Idlewyld				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Idlewyld			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6516 Beechwood Road				d. STREET ADDRESS 6516 Beechwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EILEEN Middle E. Last BUDDEMEYER				4. DATE OF DEATH Month January Day 23 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1921	
9. AGE (In years last birthday) 36 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typing (private)				10b. KIND OF BUSINESS OR INDUSTRY Typing		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Md.							
13. FATHER'S NAME Gordon L. King				14. MOTHER'S MAIDEN NAME Mary A. Werner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-18-1836		17. INFORMANT Mrs. Kathryn M. Pizza		Address Hyattsville, Md. 5010 - 60th Ave. /	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Strangulation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Strangled by husband			
20c. TIME OF INJURY Hour XX p. m. Month 1 Day 23 Year 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . <u>Homicide</u> <input checked="" type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/57		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Dickler & Sons - 17, Md.</i>				24a. REC'D BY REGISTRAR DATE 1-28-57		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

BUREAU V. 2

JAN 29 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film 6209 1-11-57 et

232

CERTIFICATE OF DEATH

00214

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY (Baltimore City)			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 11 Mos. 3 Das.			
d NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Sheppard & Enoch Pratt Hosp. Towson 4, Maryland				d. STREET ADDRESS 929 North Hill Road			
3 NAME OF DECEASED (Type or print) First Rosalie Middle Wolfe Last Buffington				4. DATE OF DEATH Month January Day 3 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 14, 1884	9 AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13 FATHER'S NAME Lawrence Wolfe				14. MOTHER'S MAIDEN NAME Annie?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial infarction DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 10 days unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 30 1957 to Jan 3, 1957 , that I last saw the deceased alive on Jan 2 , 19 57 , and that death occurred at 1:33 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry M. Murdock				ADDRESS (Street, city or town, state) Sheppard-Pratt Hosp. Towson 4, Maryland			
DATE SIGNED Jan 3, 1957							
PHYSICIAN'S NAME (Type) Harry M. Murdock, M. D.				Sheppard-Pratt Hospital, Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Vickers & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE 1/8/57		24b. REGISTRAR'S SIGNATURE Metel G...	

BUREAU V. S.

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

204 CERTIFICATE OF DEATH

00215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1824 Park Ave.		d. STREET ADDRESS 1824 Park Ave.	
3. NAME OF DECEASED (Type or print) First ANNIE Middle E. Last CAROTHERS		4. DATE OF DEATH Month Jan. Day 30 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? --	
13. FATHER'S NAME James F. Carothers		14. MOTHER'S MAIDEN NAME Clara Isenberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. Joseph H. Carothers - 1824 Park Ave., Hale-		Address thorp	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart condition decompos. abn. 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Initial heart lesion DUE TO (c) -- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -- INTERVAL BETWEEN ONSET AND DEATH 10 hrs + 4 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 to Jan 31, 1957 that I last saw the deceased alive on Jan 30th 1957 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1014 Dravas Ave - Balto - Md DATE SIGNED 10/14 Dravas Ave - Balto - Md ACTUAL SIGNATURE Frederick B. Butler M.D. PHYSICIAN'S NAME (Type) Frederick B. Butler			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/1/57	
22c. NAME OF CEMETERY OR CREMATORY Greenhill Cem.		22d. LOCATION (City, town, or county) (State) Danville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lichten & Sons - Balto.		ADDRESS 1700 N. 1st St. - Balto.	
24a. REC'D BY REGISTRAR B. L. 1957		24b. REGISTRAR'S SIGNATURE St. Geo. M. Kuffner	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 2 and 3 should be filed with the registrar.

BUREAU V. F.

FEB 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use at the burial-transit permit. Then place in remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

233

CERTIFICATE OF DEATH

Reg. Dist. No.

00216

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milford			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3610 Latham Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Buell Last Chiles				4. DATE OF DEATH Month January Day 17 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1906		9. AGE (In years last birthday) 50 yrs	10. IF UNDER 1 YEAR Months 1 Days 17	11. IF UNDER 24 HRS Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesmanager		10b. KIND OF BUSINESS OR INDUSTRY Mopar Corp.		11. BIRTHPLACE (State or foreign country) Perryville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Chiles				14. MOTHER'S MAIDEN NAME Jennie Clifton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 505-10-2357		17. INFORMANT Address Dorothy Jane Chiles - 3610 Latham Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease (c) Hypertensive Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 3 HRS 1 YR 8 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-5 , 19 56 , to 1-17 , 19 57 , that I last saw the deceased alive on 1-17 , 19 57 , and that death occurred at 5 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED B. Stanley Cohen M.D. 7306 Liberty Road Baltimore, Md. 1/17/57							
ACTUAL SIGNATURE B. Stanley Cohen				PHYSICIAN'S NAME (Type) B. Stanley Cohen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-17-57		22c. NAME OF CEMETERY OR CREMATORY Bloomfield Cemetery		22d. LOCATION (City, town, or county) (State) Bloomfield, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR Jan 21 1957		24b. REGISTRAR'S SIGNATURE Dr. Jm. Martin	

BUREAU V. S.

JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00217

CERTIFICATE OF DEATH

Reg. Dist. No.

31

234

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn Baltimore	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2120 Southland Rd.		d. STREET ADDRESS 3007 Ferndale Ave.	
3 NAME OF DECEASED (Type or print) First LUCIA Middle COBURN Last COBURN		4. DATE OF DEATH Month January Day 25 Year 19 57	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1863 Feb. 26, 1863
9. AGE (In years last birthday) 93 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Troy, Vermont		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Gallup		14. MOTHER'S MAIDEN NAME Augusta Richmond	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry A. Coburn - 3007 Ferndale Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uraemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1948 , to January, 19 57 , that I last saw the deceased alive on 24 January, 19 57 , and that death occurred at 6:00PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Millard T. Traband, Jr. M.D.		ADDRESS (Street, city or town, state) 5101 Gwynn Oak Avenue, Baltimore, 7, Maryland	
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M. D.		DATE SIGNED 26 Jan. 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/1957	
22c. NAME OF CEMETERY OR CREMATORY Sutton Village Cem.		22d. LOCATION (City, town, or county) (State) Sutton, Vermont	
23. FUNERAL DIRECTOR'S SIGNATURE ELLSWORTH ARMACOST ADDRESS 4600 Liberty Hghts.		24a. REC'D BY REGISTRAR Jan 29 1957	
24b. REGISTRAR'S SIGNATURE Dr. H. E. Martens			

BUREAU V. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, who is to be signed by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

235

CERTIFICATE OF DEATH

00218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b unknown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1100 McAdoo Ave.				e. STREET ADDRESS 1100 McAdoo Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last William P. Cole, Sr.				4. DATE OF DEATH Month Day Year January 22 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1873	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William P. Cole				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address William P. Cole, Jr. 1100 McAdoo Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - CORONARY INSUFFICIENCY DUE TO PULMONARY EDEMA - PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRO- DUE TO (c) -							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF DEATH Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 11/21 , 19 56 , to 1/21 , 19 57 , that I last saw the deceased alive on 1/21 , 19 57 , and that death occurred at 4:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Shaw M.D. 5800 FARMERS AVE. 1/23/57							
ACTUAL SIGNATURE John H. Shaw M.D.							PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D. M.D.C. 78 MD.
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Jan 26, 1957	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Homes, 4210 Belair Rd. Balto.				24a. REC'D BY REGISTRAR DATE JAN 25 '57	24b. REGISTRAR'S SIGNATURE W. L. ...		

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00219

Reg. Dist. No.

Ann 4 - Phone call from Mt. Wilson - Mo.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 23 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital		d. STREET ADDRESS 1702 Hollin Street	
3. NAME OF DECEASED (Type or print) First William Middle Frederick Last Colehouse		4. DATE OF DEATH Month January Day 6 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10.7.04
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR: Months 3 Days 1 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY COLEHOUSE		14. MOTHER'S MAIDEN NAME MARGARET KAYLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES, 1919-1921		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Hospital records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan 3 , 19 57 , to Jan 6 , 19 57 , that I last saw the deceased alive on January 6 , 19 57 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE William Newcomer M.D.		PHYSICIAN'S NAME (Type) William Newcomer, M.D. Supt. Mt. Wilson, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/9/58	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd	
24a. REC'D BY REGISTRAR 10 1957		24b. REGISTRAR'S SIGNATURE Sarah J. Newell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20.00
20.00

1911.11.11

Miss Kate contacted Mt. Zion about
date of death 3/1 57 - M²

BUREAU V

JAN 11

RECEIVED

237

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, md - rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wards Chapel Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>Ann</u> (Type or print) First <u>Ann</u> Middle <u>M.</u> Last <u>CORNER</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/80</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kunert, Fred</u>		14. MOTHER'S MAIDEN NAME <u>St. Bing - Hattie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Alfred Stephens (daughter)</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>hypertensive c.v. disease - diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Oct 10</u> , 19 <u>53</u> , to <u>present</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L Pierpont</u> M.D.		ADDRESS (Street, city or town, state) <u>8204 Liberty Rd. Balto. Md.</u> DATE SIGNED <u>1/19/57</u>	
NAME (Type) <u>Edwin L Pierpont, M.D.</u>		8204 Liberty Rd. Balto. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Dickson & Sons - Balto 17th</u>		24a. REC'D BY REGISTRAR <u>JAN 26 1957</u>	
ADDRESS <u>Balto 17th</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Martin</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>Catonsville Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>A.</u> Last <u>Corneal</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1876</u>
9. AGE (In years last birthday) <u>81</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>81</u> Days <u>80</u> Hours <u>80</u> Min. <u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ben Smith</u>		14. MOTHER'S MAIDEN NAME <u>Susan Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Walter Corneal</u>	
17. INFORMANT (Name and address) <u>Walter Corneal 6824 Belknap Rd Balto 22, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour <u>19</u> O. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 23, 1952</u> to <u>January 14, 1957</u> , that I last saw the deceased alive on <u>January 14, 1957</u> , and that death occurred at <u>7:50</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachler</u>		DATE SIGNED <u>1-14-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>		ADDRESS (Street, city or town, state) <u>Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DAK HAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>Balt., Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Corneal</u>		ADDRESS <u>6824 Belknap Rd, Balto, Md</u>	
24a. REC'D BY REGISTRAR <u>Walter Corneal</u>		24b. REGISTRAR'S SIGNATURE <u>Walter Corneal</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. T.

JAN 16 1917

RECEIVED

BUREAU V. S.

JAN 29 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

00223

249

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 11, 13, 14 Filed 1-10-57 at

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mercy Villa-Bellona Ave.				STREET ADDRESS (If rural, give location) 4 Unland Road	
3. NAME OF DECEASED (Type or Print)		(First) Florence (Middle) Brown (Last) Cotton		4. DATE OF DEATH (Month) Jan. (Day) 2, (Year) 1957	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOW	8. DATE OF BIRTH Dec. 23, 1880	9. AGE last birthday 76 yrs.	If under 1 year: Months 12 Days 10 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
13. FATHER'S NAME Louis Brown		14. MOTHER'S MAIDEN NAME Mary Myers		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS Mrs. Mary Campbell 204 Edgevale Road	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause	(a)	Cerebral Vascular Accident	12 hrs
Antecedent cause(s)	(b)	Hypertension	10 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	Diabetes	12 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		(STATE)
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 47, 1957, to 2 Jan, 1957, that I last saw the deceased alive on Jan 1, 1957, and that death occurred at 10:50 P m., from the causes and on the date stated above.

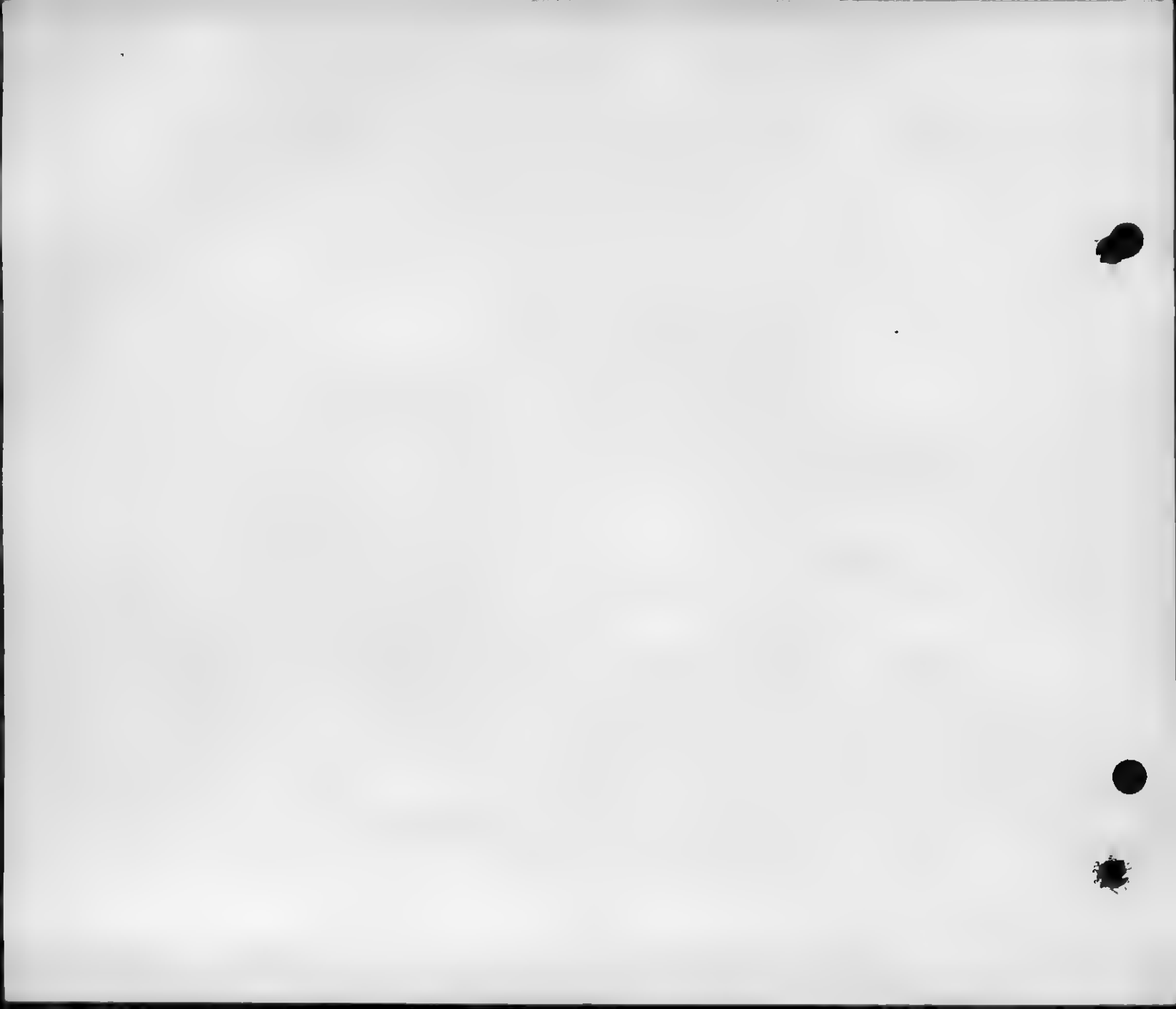
SIGNATURE S. Edwin Muller (Degree or title) ADDRESS 2 W. Read St. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Jan. 5, 1957	NAME OF CEMETERY OR CREMATORY Druid Ridge	LOCATION (City, town, or county) Pikesville,	(State) Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR John O. Mitchell & Sons Inc. 1900 Putaw Pl.		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

205

CERTIFICATE OF DEATH

00224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Pk., Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Park, Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1936 Belle Ave.		d. STREET ADDRESS 1936 Belle Ave. <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES TAYLOR CROUSE		4. DATE OF DEATH Month Day Year Jan. 21, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Riggs Ditsler	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph A. Crouse		14. MOTHER'S MAIDEN NAME Cassandra Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Sarah E. Crouse - 1936 Belle Ave., Halethorpe		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 DUE TO Chronic Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis (c) Chronic hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic renal insufficiency INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1-55 , 1955, to Jan 21, 1957 , that I last saw the deceased alive on Jan 21, 1957 , and that death occurred at 4:15 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1936 Belle Ave., Halethorpe, Md. 4/22/57			
ACTUAL SIGNATURE [Signature] M.D.		DATE SIGNED 4/22/57	
PHYSICIAN'S NAME (Type) DR. B. J. WINTROB			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/24/57	22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Tiekens & Sons - 1500 17th St.		24a. REC'D BY REGISTRAR DATE 4/22/57 24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Jeffers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 24 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

241

CERTIFICATE OF DEATH

Reg. Dist. No.

00225

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River	
c. LENGTH OF STAY IN 1b 37 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 50 Rt. 16. Middle River Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maxim Middle Crouse Last Crouse		4. DATE OF DEATH Month January Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1894
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR: Months 62 Days 62 Hours 62 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Ivan Crouse		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. Arnold M. Crouse Box 50 Rt. 16 Rd.	
17. INFORMANT Mr. Arnold M. Crouse		Address Middle River Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO arteriosclerotic Cardio-Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 yrs DUE TO (c) 2 yrs		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 1957, to Jan 19 , 1957, that I last saw the deceased alive on Jan 19 , 1957, and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G.M. Baumgardner M.D.		ADDRESS (Street, city or town, state) Balto 6 Md	
PHYSICIAN'S NAME (Type) G.M. Baumgardner		DATE SIGNED 1/19/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 22, 1957	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lewahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. RECD BY REGISTRAR JAN 22 1957		24b. REGISTRAR'S SIGNATURE Edith Harless	

BUREAU V. S.

IV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

242

CERTIFICATE OF DEATH

00226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville - 28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor</u>		d. STREET ADDRESS <u>115. Prospect Ave</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN F CROWLEY</u> First Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jerry Crowley</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Lillian Crowley</u>		Address <u>115. Prospect Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBACUTE & ACUTE MYOCARDITIS.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SENILITY & SENILE DEGENERATION.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 MO.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>0</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOV. 25, 1956</u> , to <u>JAN. 22, 1957</u> , that I last saw the deceased alive on <u>JAN. 21, 1957</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>6348 FREDERICK ROAD, CATONSVILLE, MARYLAND</u>	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>1-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>St Johns</u>		<u>Catonsville - MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Patterson</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 57</u>	
ADDRESS <u>Catonsville - 28</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

BUREAU V. 3

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

002234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Loch Raven Reservoir</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
f. STREET ADDRESS <i>1632 Aberdeen Road</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Mary Frances Cuthbert</i>		4. DATE OF DEATH <i>January 8th 19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 20, 1920</i>
9. AGE (in years last birthday) <i>36 yrs.</i>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Thomas A. Di Natale</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret Politz</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>If yes, give war or dates of service</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. John G. Cuthbert, 1632 Aberdeen Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>975X</i> DUE TO <i>Drowning</i> Conditions, if any, which gave rise to immediate cause (b) <i>Sudden</i> (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN INJURY AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/11/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>MA 10 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

RECEIVED
JAN 10 1957
BUREAU W. S.

195 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>DUNDALK</u> MARYLAND	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) <u>Dundalk</u>	(in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3121 LIBERTY PARKWAY</u>		STREET ADDRESS (If rural give location) <u>3121 Liberty Pkwy</u>	
3. NAME OF DECEASED: (First) <u>PISTRO</u> (Middle) <u>MARIA</u> (Last) <u>DACRE</u>		4. DATE OF DEATH: (Month) <u>1</u> (Day) <u>30</u> (Year) <u>1957</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>1-25-1885</u>
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: If UNDER 1 YEAR If UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>ANTHONY DACRE</u>		14. MOTHER'S MAIDEN NAME: <u>MARIA PARDO</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>FRANK DACRE 7716 BAGLEY AVE</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset and Death	
Immediate cause (a) <u>Hypertensive Cardio Vascular Disease</u>		<u>1 year</u>	
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 30</u> , 19 <u>57</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>57</u> , and that death occurred at <u>8:15 AM</u> from the causes and on the date stated above. SIGNATURE <u>W. J. Dippel</u> (Degree or title) ADDRESS <u>6800 Morningstar Ln - Dundalk Md 11317</u> DATE SIGNED <u>2/1/57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>FEB 2 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. HOLY REDEEMER</u>		LOCATION (City, town, or county) (State) <u>BELAIR ROAD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/1/57</u>		REGISTRAR'S SIGNATURE <u>W. J. Dippel</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>WENDELL J. DIPPEL 3125 Highland Ave</u>	

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST INVERNESS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>8501 KAVANAUGH Rd</u>	
3. NAME OF DECEASED (Type or print) <u>GERALDINE LYNN DAYTON</u>		4. DATE OF DEATH <u>JANUARY 19 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7 1946</u>
9. AGE (In years last birthday) <u>10</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JACK M. DAYTON</u>		14. MOTHER'S MAIDEN NAME <u>GERALDINE COX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>GERALDINE DAYTON</u>		Address <u>Dundalk, Md</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>929.8</u> DUE TO (c) <u>929.8</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>929.8</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Free Fall from Sea in Sea Creek</u>	
20c. TIME OF INJURY <u>11:45 p.m. 1/20/57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sea Creek</u>		20f. (City or town) <u>MD Dundalk or Baltimore</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M-B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Jan. 23, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cem.</u>		22d. LOCATION (City, town, or county) <u>WESTPORT MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. [Signature]</u>		ADDRESS <u>Westport, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. E.

NOV 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00230

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 53

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		c. LENGTH OF STAY IN 1b 93 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fringer Road			d. STREET ADDRESS Fringer Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Clara E. Deets			4. DATE OF DEATH Month Day Year Jan. 18, 1957 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1863		9. AGE (in years last birthday) 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob Myers			14. MOTHER'S MAIDEN NAME Emily Laudenslauger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Earl Dietz, Upperco Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOCLEROTIC C.V. DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 HRS. YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Martin E. Strobel M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) D.D. Capez			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Paul	
				22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edwin C. Tipton			24a. REC'D BY REGISTRAR DATE 1-19-57		24b. REGISTRAR'S SIGNATURE Wary B. Zline

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1977

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245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>4yr3mth9days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 3ver4</u>				d. STREET ADDRESS <u>946 Brunswick St. - Balto. 23</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>DeFord</u> Last <u>DeFord</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>February 1, 1891</u> 65 yrs	
9. AGE (In years last birthday) <u>65</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nebraska</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>George DeFord</u>				14. MOTHER'S MAIDEN NAME <u>Sarah DeFord</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Amputation of left leg due to diabetic gangrene</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12-5</u> , 19 <u>56</u> , to <u>1-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-16</u> , 19 <u>57</u> , and that death occurred at <u>5:50 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove Hospital Catonsville 28</u> DATE SIGNED <u>1/16/57</u>							
ACTUAL SIGNATURE <u>Rena Becker</u> M.D.				PHYSICIAN'S NAME (Type) <u>Rena Becker, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>January 21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Buma</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Ellsworth Buma</u>	

ELLSWORTH ARMACOST 4600 Liberty Heights Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 21 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

246

CERTIFICATE OF DEATH

00232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8551 Phila. Rd.		d. STREET ADDRESS 8551 Phila. Rd.	
3. NAME OF DECEASED (Type or print) MARY First Middle Last Diegel		4. DATE OF DEATH JAN 14 1957 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Balto. Co. Md.
13. FATHER'S NAME August Kahler		14. MOTHER'S MAIDEN NAME Mary Klein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. William J. Diegel Address 8551 Phila. Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Arterio sclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Sudden 5 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 1956 to JAN 14 , 1957, that I last saw the deceased alive on Jan 13 , 1957, and that death occurred at 12:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Baumgardner M.D.		ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 1/14/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-17-1957	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home		ADDRESS 7401 Belair Ave	24a. RECORDING REGISTRAR John E. C. DATE 1/14/57
		24b. REGISTRAR'S SIGNATURE Edith Hurley	

RECEIVED

JAN 16 1957

BUREAU W. S.

247

CERTIFICATE OF DEATH.

00233

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home				d. STREET ADDRESS 3000 E. Baltimore St.			
3. NAME OF DECEASED (Type or print) Lillian E. Dunlap				4. DATE OF DEATH Month Jan. Day 27, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1884	9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Louis Riefner				14. MOTHER'S MAIDEN NAME ? Gleitsman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT Frank T. Dunlap Address 3501 Elm Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 x 0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cornary thrombosis (c) Arterio sclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 days subacute
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/17 , 19 57 , to 1/27 , 19 57 , that I last saw the deceased alive on 1/25 , 19 57 , and that death occurred at 5:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Cliff Ratliff Jr. M.D.				ADDRESS (Street, city or town, state) 4605 Edmondson Ave			
DATE SIGNED 1/28/57							
PHYSICIAN'S NAME (Type) CLIFF RATLIFF JR. 4605 EDMONDSON AVE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran - 3000 E. Baltimore St.				24a. REC'D BY REGISTRAR JAN 30 '57		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00234

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hydes Md				c. LENGTH OF STAY IN 1b 2 mos			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUNSHINE AVE Hydes Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alva Middle Wilmont Last Ehrefeld				4. DATE OF DEATH Month Jan Day 3 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 2, 1889	
9. AGE (in years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Belmar Corp?				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Penn (Altona)	
12. CITIZEN OF WHAT COUNTRY? —							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. 216-10-5547			
17. INFORMANT Shirley M Fites				Address McCoy Rd Parkton Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, generalized, advanced DUE TO (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 1 hr undet undet							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John C. Hyle MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/6/57		Fork M.E.		Fork Md	
23. FUNERAL DIRECTOR'S SIGNATURE PAUL H. HEEMANN				ADDRESS 6667 HACEFORD RD		24a. REC'D BY REGISTRAR Dr. Walter Hammett	
				24b. REGISTRAR'S SIGNATURE			

THIS DEPARTMENT OF HEALTH EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

JAN 9 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
249
CERTIFICATE OF DEATH

00235
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Towson</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>6 MOS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 PARK AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE MARGARET EIERMAN</u>		4. DATE OF DEATH Month Day Year <u>JAN. 15, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1890</u>
9a. AGE (In years last birthday) <u>66 yrs.</u>		9b. IF UNDER 1 YEAR Months Days Hours Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home. helper. House keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>Baltimore</u>	
13. FATHER'S NAME <u>Henry Krumm</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kahl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Harry Krumm</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal, Cervical Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis from Pelvic Organ</u> DUE TO (c) <u>Operation Oct 1890</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Oct 542 1-15 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury - Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 10, 1954</u> to <u>Jan 15, 1957</u> that I last saw the deceased alive on <u>Jan 14, 1957</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. B. ENSOR</u>		ADDRESS (Street, city or town, state) <u>7201 York Rd., Balto 12 Md</u>	
PHYSICIAN'S NAME (Type) <u>C. B. ENSOR</u>		DATE SIGNED <u>Jan 21 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PIKESVILLE MARYLAND.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 21 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mabel Grays</u>	

RECEIVED

JAN 21 1957

REAU V. S.

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial-transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00236

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>				STATE <u>MD.</u> COUNTY <u>BALTO</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>DUNDALK</u>		<u>16 yrs</u>		<u>DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 SEABRIGHT AVE.</u>				STREET ADDRESS (If rural give location) <u>24 SEABRIGHT AVE</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>GEORGE WILLIAM EISENBACH</u>				<u>1-14-57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>DEC. 26, 1883</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MECHANIST</u>		<u>PRINT WORK</u>		<u>MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>GAM EISENBACH</u>				<u>ANNA SCHAEFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>2-6019349A</u>		<u>FLORENCE S. EISENBACH</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
15. IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>HEPATOMA</u>						<u>3 MO.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>19.50</u> to <u>Jan 14</u> 19.57 , that I last saw the deceased alive on <u>Jan 14</u> 19.57 , and that death occurred at <u>8:15 A</u> M, from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>William A. Mocharale</u>		<u>6714</u>		<u>Seabright Ave.</u>		<u>1-15-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-17-57</u>		<u>OAK LAWN</u>		<u>BALTO. Co. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 16 1957</u>		<u>Wm. M. Kelly Jr.</u>		<u>Walter Burke Beahy, Dundalk, Md</u>			

RECEIVED

JAN 16

BUREAU

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home, Chattalonnee Rd.</u>				d. STREET ADDRESS <u>Chattalonnee Rd. Owings Mill</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Hobson Elder</u>				4. DATE OF DEATH Month Day Year <u>Jan. 8, 1957</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/1862</u>		9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert North Elder</u>				14. MOTHER'S MAIDEN NAME <u>Susan Gordon Voss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Edward B. Whitman, Chattalonnee, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>15 yrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/11/33</u> to <u>Jan 8, 1957</u> that I last saw the deceased alive on <u>Jan 7, 1957</u> , and that death occurred at <u>5:06 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Palmer FC Williams, M.D. 1725 Reisterstown Rd 11915</u>							
ACTUAL SIGNATURE <u>Palmer FC Williams</u>				PHYSICIAN'S NAME (Type) <u>PALMER FC WILLIAMS, Pikesville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrison Forrest, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				ADDRESS <u>Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1/11/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Brothy Newell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1931
BUREAU V. 8

252

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>	
c. LENGTH OF STAY IN 1b <u>60 yrs</u>		d. STREET ADDRESS <u>1502-C-St-</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edas May Eldred</u>		4. DATE OF DEATH <u>Jan-31-57</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May-21-1890</u>
9. AGE (In years last birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR <u>1</u> MONTHS <u>31</u> DAYS <u>17</u> HOURS <u>17</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Cornelius B Doty</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca J Ferguson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr. Elmer E. Buford</u>		Address <u>1502-C-St-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>56</u> to <u>Jan-31</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Jan-31</u> 19 <u>57</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. Means</u>		DATE SIGNED <u>2-1-57</u>	
PHYSICIAN'S NAME (Type) <u>J. T. Means</u>		ADDRESS (Street, city or town, state) <u>502 St. 13 Ct 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>	22b. DATE THEREOF <u>Feb 2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart</u>		24a. REC'D BY REGISTRAR <u>4</u> 1957	
ADDRESS <u>1024 W. 1st St</u>		24b. REGISTRAR'S SIGNATURE <u>Samuel L. Farber</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 4 1957

RECEIVED

253

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fork Rd.		d. STREET ADDRESS Fork Rd.	
3. NAME OF DECEASED (Type or print) First Henry Middle F. Last Emmel		4. DATE OF DEATH Month January Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Emmel		14. MOTHER'S MAIDEN NAME Mary E. Laubach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 218-14-9382A	
17. INFORMANT Mrs. Caroline A. Emmel		Address Fork Rd. Baldwin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1930 to Jan 21, 1957 that I last saw the deceased alive on Jan 21, 1957 , and that death occurred at 8:45 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baldwin DATE SIGNED Jan 21-57 ACTUAL SIGNATURE Halter Hammett M.D. Halter Hammett PHYSICIAN'S NAME (Type) Halter Hammett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR JAN 22 1957		24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett	

BUREAU V. S.

JAN 22 1957

WV

206

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABBYTUS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABBYTUS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1208 Leeds Ave</u>		d. STREET ADDRESS <u>1208 Leeds Ave</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES W. WILKENS JR</u>		4. DATE OF DEATH <u>Jan. 19, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11c. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>----- Pink</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>101-10-10101</u>	
17. INFORMANT <u>Margaret Wilkens</u>		Address <u>1208 Leeds Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 18, 1956</u> , to <u>Jan 15, 1957</u> , that I last saw the deceased alive on <u>Jan 18, 1957</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl Pass, M.D.</u>		DATE SIGNED <u>Jan 29, 1957</u>	
PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>		ADDRESS <u>400 Wilkens Ave Pk 29 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-19-57</u>	22b. DATE THEREOF <u>1-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. ...</u>		ADDRESS <u>1111 N. ...</u>	
24a. REC'D BY REGISTRAR <u>Jan 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00241

CERTIFICATE OF DEATH

Reg. Dist. No. 38

254

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8603 Goetze Avenue</u>		d. STREET ADDRESS <u>8603 Goetze Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELMER T. ENGLISH</u>		4. DATE OF DEATH Month Day Year <u>January 10, 1957</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 10, 1888</u>
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James W. English</u>	
14. MOTHER'S MAIDEN NAME <u>June D. Johnson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WW I</u>	
16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Family records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lungs</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>55</u> , to <u>1/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/18</u> , 19 <u>27</u> , and that death occurred at <u>2:50</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon M. Gray</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8513 Jack Raven Blvd Towson 4 MD 1/17/57</u>	
PHYSICIAN'S NAME (Type) <u>GORDON GRAU</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>
23a. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u>		ADDRESS <u>Towson, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Jan. 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	

BUREAU V. S.

JAN 1957

ED

255

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTIMORE</u> MARYLAND			STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SHEPPARD + ENOCH BATT HOUSE</u>			STREET ADDRESS (If rural give location) <u>503 CASTLE DRIVE</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM DEMAIRELLE FRASER</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>1 - 15 19 57</u>		
5. SEX: <u>M</u>			6. COLOR OR RACE: <u>W</u>		
7. <u>SINGLE</u> MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>			8. DATE OF BIRTH: <u>10-31-02</u>		
9. AGE last birthday: <u>54</u> yrs.			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired. <u>REG. NURSE</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>HOSPITAL</u>		
11. BIRTHPLACE (State or foreign country): <u>RHODE ISLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME: <u>(UNKNOWN) - FRASER</u>			14. MOTHER'S MAIDEN NAME: <u>BELLE FRASER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			16. SOCIAL SECURITY No.: <u>037-18-5857</u>		
17. INFORMANT & ADDRESS: <u>Mrs. Wm. Fraser 503 Castle Drive Baltimore</u>					

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary occlusion</u>		<u>immediate</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>none known</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>none known</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>1-15</u> , 19 <u>57</u> , to <u>1-15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>57</u> , and that death occurred at <u>9:05 AM</u> , from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>William H. Edwards, M.D.</u>		ADDRESS <u>Box 6815 Towson - 9 Md. 1-15-57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>JAN. 15, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>DRABBLE-SHERMAN F.H.</u>		LOCATION (City, town, or county) (State) <u>PROVIDENCE, R.I.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 15, 1957</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>		ADDRESS <u>Deputy Medical Examiner, Dr. Rella Hudson, notified 1-15-57.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

N. 18 1957

RECEIVED

256

CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge				c. LENGTH OF STAY IN 1b 20			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last FREBURGER				4. DATE OF DEATH Month Jan. Day 26, Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1868		9. AGE (In years last birthday) 88 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Chief Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Freburger				14. MOTHER'S MAIDEN NAME Josephine -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Ruth E. Tracey - 1432 Girard St., N.W. DC		Address Washington 9,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart coronary arteriosclerosis						2-6-57	
4. 1 DUE TO hypertension (long standing)						1957	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO arteriosclerosis						5-7-57	
(c) hypertension						10-4-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 19, 1957 to June 26, 1957 that I last saw the deceased alive on June 26, 1957 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.						DATE SIGNED 10-9-57	
PHYSICIAN'S NAME (Type) Elkridge - 7-4-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto., Md.				24a. REC'D BY REGISTRAR DATE 1-28-57		24b. REGISTRAR'S SIGNATURE E. Bird Williams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 29 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Inverness</u>		c. LENGTH OF STAY IN 1b <u>West Inverness</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>8446 Kavanagh Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Valerie Michele Lebrun</u>		4. DATE DEATH Month Day Year <u>Jan 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Dec 25 1946</u>	9. AGE (In years last birthday) <u>10</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School girl</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Jacob H Lebrun</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Jacob H Lebrun</u>	
17. ADDRESS <u>8446 Kavanagh Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell thru log into Bear Creek</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-19-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bear Creek</u>		20f. (City or town) <u>Dundalk - 22</u> (County) <u>Baltimore</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>		DATE SIGNED <u>1/20/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto Cem</u>		22d. LOCATION (City, town, or county) <u>Baltimore</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William James Home</u>		24. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 7 1957

RECEIVED

258 CERTIFICATE OF DEATH

00245

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>615 Aldershot Rd</u>		d STREET ADDRESS <u>615 Aldershot Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Prentz Jr.</u>		4 DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Prentz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Magleth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>216-07-9197</u>	
17. INFORMANT <u>Mrs Ada Prentz, 615 Aldershot Rd.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>50</u> , to <u>1-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.W. JACOBSON MD</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2310 Eutaw Place 1-8-57</u>	
PHYSICIAN'S NAME (Type) <u>M.W. JACOBSON MD</u>		<u>2310 Eutaw Place</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witke</u>		ADDRESS <u>1101 ... on Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 9 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 9 1957

BUREAU V. S.

259

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Windwood Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last FRITZ				4. DATE OF DEATH Month Jan. Day 29 , Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 22, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Clerk				10b. KIND OF BUSINESS OR INDUSTRY Fraternal Order		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Fritz				14. MOTHER'S MAIDEN NAME Emilie Willms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Lily W. Fritz - 507 Windwood Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from JUN 20, 1953 , to JAN 29, 1957 , that I last saw the deceased alive on JAN 29, 1957 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 Md. DATE SIGNED 1/30/57							
ACTUAL SIGNATURE Laurence C. Post M.D.							
PHYSICIAN'S NAME (Type) LAURENCE C. POST							
22a. BURIAL, CREMATION, or REMOVAL (Specify) Entombment		22b. DATE THEREOF 2/1/57		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem. Maus/		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thm J. Viscione & Sons				ADDRESS Balto 17th St		24a. REC'D BY REGISTRAR DATE 1 1957	
				24b. REGISTRAR'S SIGNATURE Mabel Gray			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 4 1957

RECEIVED

260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor, 5743 Edmondson Avenue				e. STREET ADDRESS Westminster			
3. NAME OF DECEASED (Type or print) First Julia Middle Winefred Last Fouke				4. DATE OF DEATH Month January Day 30 Year 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1860		9. AGE (In years last birthday) 96 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Westminster Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Smith				14. MOTHER'S MAIDEN NAME Louise Capito			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Arthur Smith, 3605 Hillside Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Occlusion 252X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 months 15 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 1953 , to JAN. 30, 1957 , that I last saw the deceased alive on JAN. 23, 1957 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Nelson McKay		M.D. 6014 Edmondson Ave. Bldg. 28, Md. DATE SIGNED 1/31/57					
PHYSICIAN'S NAME (Type) J. Nelson McKay, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-57		22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 21 57	
				24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

78 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00248

261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>470 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>1026 Booth Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>(NME)</u> Last <u>GARNETT</u>		4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>19 57</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 9, 1894</u>				
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pool Room</u>					
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Jennifer Garnett</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Crump</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>					
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS, MIDDLE CEREBRAL ARTERY, LEFT</u> DUE TO <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>7 MONTHS</u> <u>UNKNOWN</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u>VA</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>September 28, 1955</u> , to <u>January 10, 1957</u> , and that death occurred at <u>3:10 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Fort Howard, Maryland</u> DATE SIGNED <u>1/10/57</u>							
ACTUAL SIGNATURE <u>Irving Freeman</u> M.D. <u>VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>1/10/57</u>					
PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D., Chief, Medical Service V.A.H., Ft. Howard, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Sept-13, 1957</u>		22b. DATE THEREOF					
22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Mariaica, Virginia</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Katie Williams</u>		24a. REC'D BY REGISTRAR <u>Jan 11 1957</u>					
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Luby</u>		ADDRESS <u>322 W. Schroeder St. Balto. Md.</u>					

BUREAU V. S.

JAN 14 1972

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00249

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb 2 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 509 FAIRMOUNT AVE		d. STREET ADDRESS 509 FAIRMOUNT AVE	
3. NAME OF DECEASED (Type or print) CHARLES SILBURN GARTON		4. DATE OF DEATH Month JAN Day 13 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/87
9. AGE (in years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINOTYPE		10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SPOTSWOOD F. GARTON		14. MOTHER'S MAIDEN NAME HOOVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT WIFE - MRS STELLA Address 509 FAIRMOUNT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 YRS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William A. Pillsbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 1/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 15, 1957	22c. NAME OF CEMETERY OR CREMATORY Jacksonville Reformed	22d. LOCATION (City, town, or county) (State) Jacksonville, Balto. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR JAN 14, 1957	24b. REGISTRAR'S SIGNATURE Mabel C. Gray

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be delivered to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 16 1957

RECEIVED

Reg. Dist. No.

263

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 6, D. C.	
f. STREET ADDRESS 105 - 11th St., N. W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle F. Last Gegan		4. DATE OF DEATH Month Jan Day 3 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1870
9. AGE (In years) 86 (month) yr.		IF UNDER 1 YEAR Months 86 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Scranton, Penna.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Gegan		14. MOTHER'S MAIDEN NAME Katherine Morrissey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Miss Anne M. Mc Keever 2100 Conn Ave Wash 8 D. C.	
17. INFORMANT Miss Anne M. Mc Keever		Address 2100 Conn Ave Wash 8 D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior sclerotic cardio vascular disease DUE TO (c) 10 years			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 27th, 1956 , to January 3, 1957 , that I last saw the deceased alive on January 3, 1957 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P.D. Flynn		ADDRESS (Street, city or town, state) 11 East Chase Street #2	
PHYSICIAN'S NAME (Type) Philip D. Flynn, M.D.		DATE SIGNED 1/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 5, 1957	22c. NAME OF CEMETERY OR CREMATORY Cathedral
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Wearer		24a. REC'D BY REGISTRAR Jan 7 1957	
ADDRESS Calvert St.		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

264

CERTIFICATE OF DEATH

Reg. Dist. No. 00251

1. PLACE OF DEATH o COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
c. LENGTH OF STAY IN 1b 4 MOS.		d. STREET ADDRESS 1036 WILMOT COURT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CATON RIDGE NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA M. GEHRING		4. DATE OF DEATH Month Day Year JANUARY 26, 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1865
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES C. GEHRING		14. MOTHER'S MAIDEN NAME KATHERINE DeBAUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR. ARTHURE. PARKS 727 SPRINGFIELD AVE.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis chronic with failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial hypertrophy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advancing years			INTERVAL BETWEEN ONSET AND DEATH 5 years 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) no injury
21. I certify that I attended the deceased from October 1956 , to January 26, 1957 , that I last saw the deceased dead on January 26, 1957 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James Graham Marston M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 516 Cathedral Street, Baltimore Md. I-27-57	
PHYSICIAN'S NAME (Type) James Graham Marston		516 Cathedral Street Baltimore Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/29/57	22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTO. MD.		24a. REC'D BY REGISTRAR DATE JAN 31 57	
24b. REGISTRAR'S SIGNATURE Quinn			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

265

CERTIFICATE OF DEATH

00252 4 4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>39 Days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				d. STREET ADDRESS <u>412 S. Stricker Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>P.</u> Last <u>GEORGE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>November 4, 1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber's Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Company</u>		11. BIRTHPLACE (State or foreign country) <u>Summer Hill, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Jacob George</u>				14. MOTHER'S MAIDEN NAME <u>Esther Crum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO <u>030-07-6676</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ENCEPHALOMALACIA</u> DUE TO <u>RECURRENT VASCULAR THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION POSTERIOR WALL, LEFT VENTRICLE AT THE VERTEX</u> (c) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>December 1</u> , 19 <u>56</u> , to <u>January 9</u> , 19 <u>57</u> , and that death occurred at <u>2:25 A.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>1/10/57</u>							
ACTUAL SIGNATURE <u>Rolando D. Ponce de Leon</u> M.D.				PHYSICIAN'S NAME (Type) <u>ROLANDO D. PONCE DE LEON, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Ce.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6000 Harford Rd., Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>1/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Gaskin</u>	

Wm. Cook-Blight

BUREAU V. S.

JAN 14 1911

RECEIVED

266

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 3810 Foster Avenue		
3. NAME OF DECEASED (Type or print) First Agatha Middle Bretzel Last Gephardt			4. DATE OF DEATH Month January Day 16 , Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1891	9. AGE (in years last birthday) 65 yrs.	IF UNDER 1 YEAR: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Clement Bretzel			14. MOTHER'S MAIDEN NAME Cunigunda		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile arteriosclerotic nephrosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 17, 1956 , to Jan. 16, 1957 that I last saw the deceased alive on Jan. 16, 1957 , and that death occurred at 11:00a.m. from the causes and on the date stated above.					
ACTUAL SIGNATURE Stella Wachslor M.D.			ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 1-16-57		
PHYSICIAN'S NAME (Type) Stella Wachslor, M.D.			Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
BURIAL		1-19-57		SACRED HEART CEM.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jech		ADDRESS 6044 Eastview MD.		24a. REC'D BY REGISTRAR DATE 1/18/57	
				24b. REGISTRAR'S SIGNATURE R. W. Hedwich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JAN 21 1957

U. S. DEPARTMENT OF THE ARMY

267

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS PT.		c. LENGTH OF STAY IN 1b 65 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 911 D ST.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT (19)	
3. NAME OF DECEASED (Type or print) First ARNES Middle ROBINSON Last GILBERT		4. DATE OF DEATH Month 1 Day 17 Year 57	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 21, 1879
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME (UNK)		14. MOTHER'S MAIDEN NAME KATE (UNK)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MORRIS L. GILBERT		Address SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular disease DUE TO (c) Vascular disease		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955 , to Jan. 17, 1957 , that I last saw the deceased alive on Jan. 16, 1957 , and that death occurred at 12:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE David Owens		DATE SIGNED 914 D Street Balto. MD 11/17/57	
PHYSICIAN'S NAME (Type) DAVID OWENS			
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF	
BURIAL		1-19-57	
22c. NAME OF CEMETERY OR CREMATORY WESTERN		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter R. Riddle, Dundalk, Md.		24a. REC'D BY REGISTRAR Jan 21 1957	
24b. REGISTRAR'S SIGNATURE Lawson L. Fisher			

BUREAU V. S.

JAN 21 1957

RECEIVED

268

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 Newberg Ave.				e. STREET ADDRESS 123 Newberg Ave.			
3. NAME OF DECEASED (Type or print) First Eva Middle Rece Last Giles				4. DATE OF DEATH Month Jan. Day 9 Year 19 57			
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 182	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Evans				14. MOTHER'S MAIDEN NAME Hannah Moule			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Margaret Harrison 123 Newberg Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 592 ✓ DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic hepatitis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Dec 23 , 19 56 , to Jan 9 , 19 57 , that I last saw the deceased alive on Jan 9 , 19 57 , and that death occurred at 7 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE R. G. Lally		M.D. 3517 EDMONDSON AVE		DATE SIGNED Jan 14 '57			
PHYSICIAN'S NAME (Type) LA. L. LALLY MD		3517 EDMONDSON AVE					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1-12-57	22c. NAME OF CEMETERY OR CREMATORY London Park	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Harley Ann. Hone			ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 '57	24b. REGISTRAR'S SIGNATURE Overman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 14 1937
BUREAU V. S.

269

CERTIFICATE OF DEATH

00256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>35 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>L.</u> Last <u>GIVEN</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1957</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/29/89</u>	
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Government Sheet metal work</u>		11. BIRTHPLACE (State or foreign country) <u>Tarentum, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas D. Given</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Hardie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital., Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTS, ACUTE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>December 3, 1956</u> , to <u>January 7, 1957</u> , that death occurred on <u>January 7, 1957</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Maryland</u> DATE SIGNED <u>1/7/57</u> ACTUAL SIGNATURE <u>Rolando D. Ponce de Leon</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u> PHYSICIAN'S NAME (Type) <u>ROLANDO D. PONCE DE LEON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

BUREAU V. E.

JAN 9 1957

RECEIVED

270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>		d. STREET ADDRESS <u>4920 Queensberry Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Rubin</u> Middle <u>Glassman</u> Last <u>Glassman</u>		4. DATE DEATH <u>Jan</u> <u>10</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Glassman</u>		14. MOTHER'S MAIDEN NAME <u>Nettie?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rebecca Glassman - 4920 Queensberry Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - Thrombosis</u> <u>4211</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis, Chr. Coronary disease months</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Jan 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Bernard Cohen</u> M.D.		THE MARYLAND APLS	
PHYSICIAN'S NAME (Type) <u>DR. BERNARD COHEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 11/57</u>	<u>Bnai Israel</u>	<u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Inc</u> ADDRESS <u>Solgerman + 1202 - 1124-26th North Ave</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>JAN 14 57</u>	<u>Rebecca</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 14 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00258
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklintown			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklintown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5306 Dogwood Road					d. STREET ADDRESS 5306 Dogwood Road			e. 15 RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD F. GOHR					4. DATE OF DEATH Month Day Year 1- 13 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 30, 1897		9. AGE (In years last birthday) 59		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edward F. Gohr					14. MOTHER'S MAIDEN NAME Ella A. Kidwell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.1 214-03-5206		17. INFORMANT Lillian M. Gohr 5306 Dogwood Road						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002X DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (b) Acute alcoholism (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.0										INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>R. S. Fisher</i>					M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 1-13-57		
EXAMINER'S NAME (Type) R. S. FISHER					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-16-1957		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park			22d. LOCATION (City, town, or county) (State) Woodlawn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard Strong</i>					24a. REC'D BY REGISTRAR 15-57		24b. REGISTRAR'S SIGNATURE <i>Outreach</i>			

STAN V. S.

JAN 1, 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00259

272

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McDonogh</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>604 Military Ave. Pikesville, Md.</u>			
c. LENGTH OF STAY IN 1b <u>Lifetime</u>				d. STREET ADDRESS <u>604 Military Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McDonogh School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>EDWARD</u> Last <u>Gorrie</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 9, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor-Bookkeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Gorrie</u>				14. MOTHER'S MAIDEN NAME <u>Elva Booth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-32-0432</u>		17. INFORMANT Address <u>Joseph H. Aten Box 275H Pasadena, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO <u>few years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1952</u> to <u>10 JAN</u> , 1957, that I last saw the deceased alive on <u>26 May</u> , 1956, and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>808 Reisterstown Rd. Pikesville 8 MD</u>				DATE SIGNED <u>10 Jan 57</u>			
ACTUAL SIGNATURE <u>Paul H Royce</u>							
PHYSICIAN'S NAME (Type) <u>Paul H Royce MD. Pikesville 8 MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 12, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Howell, Pikesville</u>				24a. REC'D BY REGISTRAR <u>Mary Eline</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Eline</u>	
				DATE <u>14 1957</u>			

BUREAU V. S.

JAN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

273

CERTIFICATE OF DEATH

00260

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1525 W. Lanvale Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HOWARD Middle F. Last GRIFFIN		4. DATE OF DEATH Month January Day 16 Year 19 57					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1924	9. AGE (In years last birthday) yrs. 32	IF UNDER 1 YEAR Months Days Hours Min 	IF UNDER 24 HRS. Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Housing Authority		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howard Griffin				14. MOTHER'S MAIDEN NAME Marian Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give no. or dates of service) WW II 212-20-4844		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446x HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1.5 Hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 13, 1957 to January 16, 1957 , and that death occurred at 12:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald Mark		ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 1/16/57					
PHYSICIAN'S NAME (Type) DONALD MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes Funeral Home, 638 N. Gilmore St.				ADDRESS Baltimore, Maryland		24a. REC'D BY REGISTRAR 1/17/57	
				24b. REGISTRAR'S SIGNATURE Dawson L. Farberg			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 19

RECEIVED
JAN 19

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00261

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTC</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTC</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex-Middle River</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex-Middle River 20</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MARTIN Aircraft "C" Bldg Hosp.</u>			d. STREET ADDRESS <u>54 Henderson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CANARY</u> First <u>Edmond</u> Middle <u>HALE</u> Last			4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-19</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>		11. BIRTHPLACE (State or foreign country) <u>COMER'S ROCK LA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>CANARY E. Hall</u>		
14. MOTHER'S MAIDEN NAME <u>Lura Stamper</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1943-1946</u>		
16. SOCIAL SECURITY NO. <u>228-16-2466</u>			17. INFORMANT <u>Mr. Hubert Harmon</u> Address <u>54 Henderson Rd.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution (Accidental)</u> 914.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>5 Sec</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Grasped High tension Wires</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Jack E. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Jack E. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belair New Park</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Mahan Funeral Home</u>			24a. REC'D BY REGISTRAR <u>DATE 1/28/57</u>		
ADDRESS <u>7401 Belair Rd.</u>			24b. REGISTRAR'S SIGNATURE <u>Edith Kureya</u>		

RECEIVED

JAN 23 1957

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 0

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Roscoe</u> Last <u>Hammond</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1957</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Live Stock</u>	
11. BIRTHPLACE (State or foreign country) <u>Kingsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Hammond</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Ledley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Jennie E. Hammond, Kingsville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Rectum</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 mo. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1956</u> to <u>Jan. 13, 1957</u> , that I last saw the deceased alive on <u>Jan. 13, 1957</u> , and that death occurred at <u>10:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u>	
DATE SIGNED <u>1-15-57</u>			
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 17, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u> <u>Howard K. McComas</u>		ADDRESS <u>Abingdon Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>1-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>WM. H. Himmelfarb</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00263

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>22 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>2731 E. Monument Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES M. HAUSNER</u>				4. DATE OF DEATH Month Day Year <u>January 17 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1883</u>		9. AGE (In years last birthday) <u>73</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Hausner</u>				14. MOTHER'S MAIDEN NAME <u>Mary MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>OW</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOWER NEPHRON NEPHROSIS</u> DUE TO <u>TRANSURETHRAL RESECTION OF PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u> <u>9 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>L. Pneumonitis right lower lobe. Plasma defects affecting coagulation (fibrinolytic enzyme)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 26, 1956</u> , to <u>January 17, 1957</u> and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. <u>Joseph M. Miller</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. Veterans Administration Hospital 1/17/57</u>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>JOSEPH M. MILLER, M.D., Chief, Surgical Service</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, Inc.</u> <u>2601 E. Madison St.</u>				24a. REC'D BY REGISTRAR <u>DATE 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Larkins</u>	

Schimunek Funeral Home, 2601 E. Madison St., Baltimore, Md.

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JAN 21 1957

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Wampler Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertie G. Hensley		4. DATE OF DEATH Month Jan. Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months 18 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Roanoke Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Hensley	
14. MOTHER'S MAIDEN NAME Birch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Leonard Hensley 213 Wampler Rd. 20	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses DUE TO Cerebral sclerosis Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) Cerebral sclerosis Generalized		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basine Cerebral		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 30, 1956 to Jan 18, 1957 , that I last saw the deceased alive on Jan 17, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3001 Shannon Drive Balto. 13, Md. DATE SIGNED Jan 13 1957			
ACTUAL SIGNATURE Walter A. Anderson M.D.		PHYSICIAN'S NAME (Type) Walter A. Anderson 3001 Shannon Drive Balto. 13, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF I-2I-57	
22c. NAME OF CEMETERY OR CREMATORY Sherwood Cem.		22d. LOCATION (City, town, or county) (State) Roanoke Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn T. Home 7401 Babin Rd. Balto. Md.		24. REC'D BY REGISTRAR JAN 21 1957	
24b. REGISTRAR'S SIGNATURE Edith Hurley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please register the carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 21 1957

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278 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN lb 1 month, 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Pr. George's Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month 1 Day 5 Year 1957		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/90		9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months 1 Days 5		IF UNDER 24 HRS Hours 1 Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ? Unknown		14. MOTHER'S MAIDEN NAME ? Schubelbein		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HEGERTHICKMANN Address 6005 REAMY DRIVE SKYLINE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition and dehydration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Psychosis with cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH weeks 1 year years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 19 Month 1 Day 5 Year 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Spring Grove State Hospital		(County) Pr. George's Co.		(State) Md.		21. I certify that I attended the deceased from 12/3 , 19 56 , to 1/5 , 19 57 , that I last saw the deceased alive on 1/5 , 19 57 , and that death occurred at 3 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 1/5/57			
ACTUAL SIGNATURE Stella Wachler		M.D. Stella Wachler		PHYSICIAN'S NAME (Type) STELLA WACHLER		22a. REC'D BY REGISTRAR DATE 1/5/57			
22b. DATE THEREOF Jan. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Odessa Hill Cem.		22d. LOCATION (City, town, or county) Suitland Maryland		22e. REGISTRAR'S SIGNATURE W. W. Chambers			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		ADDRESS Riverside Rd.		24a. REC'D BY REGISTRAR DATE 1/5/57		24b. REGISTRAR'S SIGNATURE W. W. Chambers			

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JAN 9 1957
BUREAU V. S.

279

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1003 Wagner Rd.		d. STREET ADDRESS 1003 Wagner Rd.	
3. NAME OF DECEASED (Type or print) First NATHAN Middle B. Last HIGGINS		4. DATE OF DEATH Month Jan. Day 12, Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR: Months 71 Days 71 Hours 71 Min. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Pres.		10b. KIND OF BUSINESS OR INDUSTRY Power & Lighting	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Eleazer E. Higgins		14. MOTHER'S MAIDEN NAME Martha A. Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-07-2042A	
17. INFORMANT Mrs. Gertrude H. Higgins - 1003 Wagner Rd.		Address Ruxton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 154x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Carcinoma of Rectum DUE TO (c) Sudden 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 51 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1957 to January 1957 , that I last saw the deceased alive on deceased , 19 57 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 2501 York Rd	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.		DATE SIGNED Tolson #4 Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17th		24a. REC'D BY REGISTRAR DATE 1/16/57	
24b. REGISTRAR'S SIGNATURE Hubel Gray			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OKay Charles F. O'Donnell M.D.

BUREAU V. S.

JAN 17 1917

RECEIVED

280

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>337 Maple Av (28)</u>	
3 NAME OF DECEASED (Type or print) <u>Shannah Teresa Hickey</u>		4. DATE OF DEATH <u>January 4 - 1959</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15/1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Geo. W. McClelland</u>		14. MOTHER'S MAIDEN NAME <u>M. Frances Dougherty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Isabella M. Hickey</u>		Address <u>48 E. Towson</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>41</u> , to <u>Jan 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>114</u> , 19 <u>57</u> , and that death occurred at <u>home</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold P. Lagia</u> M.D.		ADDRESS (Street, city or town, state) <u>326 Frederick St Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>H. P. ALAGIA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Catholic Burial</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Hovens</u> ADDRESS <u>Balto. Md</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 7 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 of this form should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1937

RECEIVED

281

CERTIFICATE OF DEATH

00268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSP.</u>		d. STREET ADDRESS <u>3 CENTRE PLACE DUNDALK</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>HISLEY</u> Last <u>HISLEY</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 9, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>HISLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MISS THERESA HISLEY</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ABCESS LEFT SHOULDER</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20</u> , 19 <u>57</u> , to <u>1-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jerome E. Shapiro</u> M.D.		ADDRESS (Street, city or town, state) <u>4003 Wilton Rd. Balto</u>	
PHYSICIAN'S NAME (Type) <u>Jerome E. Shapiro</u>		DATE SIGNED <u>1-1-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC</u> ADDRESS <u>BALTIMORE MARYLAND.</u>		24a. REC'D BY REGISTRAR <u>57</u> DATE <u>1-1-57</u>	24b. REGISTRAR'S SIGNATURE <u>Chas. E. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

282

CERTIFICATE OF DEATH

00269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Edmondale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Edmondale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5412 Addington Road		d. STREET ADDRESS 5412 Addington Road	
3. NAME OF DECEASED (Type or print) First Robert Middle Levin Last Hodson		4. DATE OF DEATH Month Jan. Day 9 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR: Months 9 Days 9 Hours 19 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Belmar Co.	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Eugene Hodson		14. MOTHER'S MAIDEN NAME Celeste Brommell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-07-9158	
17. INFORMANT Mrs. Margaret L. Eidman		Address 5412 Addington Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO CHEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EDEMA (c) ANCAEMIA			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/1 19 57 to 1/9 19 57 , that I last saw the deceased alive on 1/9 19 57 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5801 EDMONDALE AVE. DATE SIGNED 1/9/57			
ACTUAL SIGNATURE John H. Shaw M.D.		PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-1957	
22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Strong		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE R. H. Hedrick			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 11 1957

RECEIVED

283

CERTIFICATE OF DEATH

Reg. Dist. No.

00270

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa Nursing Home		d. STREET ADDRESS 4504 Hamilton Ave.	
3. NAME OF DECEASED (Type or print) First Frances J. Middle Hoerner Last 		4. DATE OF DEATH Month Jan. Day 7, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1867
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hausner		14. MOTHER'S MAIDEN NAME Mary Millbauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louis J. Reichart		Address 4504 Hamilton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to Jan 7 , 1957, that I last saw the deceased alive on Jan 7 , 1957, and that death occurred at 6 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William G. Helfrich M.D.		ADDRESS (Street, city or town, state) 5006 Roland Ave. Balto. 10 DATE SIGNED 1/9/57	
PHYSICIAN'S NAME (Type) William G. Helfrich		5006 Roland Ave. Balto. 10, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	24a. REC'D BY REGISTRAR 10 10 1957 DATE
		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 10 1957

BUREAU V. E.

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>812 Register ave</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armacost Nursing Home</u>		d. STREET ADDRESS <u>4309 E. North Hall Road</u>	
3. NAME OF DECEASED (Type or print) <u>VIOLET</u> First Middle Last <u>B</u> <u>HOFIF</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1864</u>
9. AGE (In years last birthday) <u>92</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Worthington Hoff</u>		14. MOTHER'S MAIDEN NAME <u>Violet Hand Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>700</u>	
17. INFORMANT <u>Charles W. Hoff, Falls Rd. Lutherville</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Essential Hypertension, Cardiac</u> DUE TO (b) <u>Hypertensive Impending Failure</u> DUE TO (c) <u>Cerebral hemorrhage, gangrene Mt. Fat</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Pneumonia Bilateral</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1936</u> , 19 <u> </u> , to <u>Jan 12, 1957</u> , that I last saw the deceased alive on <u>Jan 12, 1957</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above. <u>JAN 13</u> ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Ralph G. Hills</u> M.D.			
PHYSICIAN'S NAME (Type) <u>RALPH G. HILLS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 14, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons, York Road</u>		24a. REC'D BY REGISTRAR DATE <u>16 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

CORONAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

285 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CATONSVILLE</u>				TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOUSE IN THE PINES</u>				STREET ADDRESS (If rural give location) <u>843 W. 36th St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)				
<u>WILLIAM M. HOFFACKER</u>			<u>JAN 12, 1957</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.		
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>NOV 21, 1871</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>INSPECTOR</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>BALTO. CITY</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>?</u>			14. MOTHER'S MAIDEN NAME: <u>?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY No.: <u>217-26-6658</u>		17. INFORMANT & ADDRESS: <u>Wm F. Hoffacker Sr. 6015 Sefton Ave.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			18. MEDICAL CERTIFICATION				
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death				
Immediate cause (a) ... <u>334X</u> <u>Cerebrovascular artery occlusion</u>			<u>2 yrs.</u>				
Antecedent cause(s) (b) ... <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</u> <u>arteriosclerosis</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS			Conditions contributing to the death but not related to the disease or condition causing death. <u>Macular optic atrophy</u>				
19a. DATE OF OPERATION:			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)			PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)
SUICIDE			INJURY				
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>56</u> , to <u>JAN 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JAN 10</u> , 19 <u>57</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. H. McPherson</u>			ADDRESS <u>6014 Sefton Ave.</u>		DATE/SIGNED <u>1/12/57</u>		
23. BURIAL, CREMATION, REMOVAL (Specify)			DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)
<u>Burial</u>			<u>JAN 15 1957</u>		<u>LORRAINE PARK</u>		<u>BALTO</u>
DATE REC'D BY LOCAL REGISTRAR <u>JAN 14 '57</u>			REGISTRAR'S SIGNATURE <u>W. H. ...</u>		24. FUNERAL DIRECTOR <u>Paul E. ...</u> ADDRESS <u>365429 Chestnut Ave</u>		

MARGIN RESERVED FOR BANDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00273 38

Reg. Dist. No.

286

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7816 Sheppard Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mr. Fred</u> Middle <u>Rollin</u> Last <u>Hollis</u>				4. DATE OF DEATH Month <u>January</u> Day <u>16th</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Horticulturist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>			
13. FATHER'S NAME <u>Charles Hollis</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT Address <u>Mrs. Kathryn L. Hollis, 7816 Sheppard</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u>				DATE SIGNED <u> </u>			
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gosport Cemetery</u>		22d. LOCATION (City, town, or county) <u>Gosport, Indiana</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>1 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Bacon</u>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

JAN 18 1957

RECEIVED

287 CERTIFICATE OF DEATH

00274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Fairview Ave.		d. STREET ADDRESS 2 Fairview Ave.	
3. NAME OF DECEASED (Type or print) First HELEN Middle HOLMES Last		4. DATE OF DEATH Month Jan. Day 11, Year 1957	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1893
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Middlesex Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Monroe		14. MOTHER'S MAIDEN NAME Mary Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Roy Holmes		Address 2 Fairview Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer (Intestinal) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 74 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-30-56 , 19____, to 1-11-57 , 19____, that I last saw the deceased alive on 1-11-57 , 19____, and that death occurred at 3:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane. Balto. DATE SIGNED 1-11-57			
ACTUAL SIGNATURE C.F. Maloney M.D. 57 Winters Lane. Balto.			
PHYSICIAN'S NAME (Type) C.F. Maloney, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Western Star Cem	22d. LOCATION (City, town, or county) (State) Catonsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. R. Williams		ADDRESS 302 N. Howard St.	24a. REC'D BY REGISTRAR DATE JAN 14 '57
24b. REGISTRAR'S SIGNATURE Wm. H. R. Williams			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN. 15 1957
BIRMINGHAM V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

288

CERTIFICATE OF DEATH

00275

33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 19 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. STREET ADDRESS 1200 Circle Drive			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alma Middle Marie Last HOWSER				4. DATE OF DEATH Month 1 Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8/32	
9. AGE (In years last birthday) 24 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward Earl Howser		14. MOTHER'S MAIDEN NAME ALMA MORRMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Aspiration Pneumonia 491X DUE TO 2. Congenital epilepsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH 3 days since birth </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/14/57 , 19____, to 1/17/57 , 19____, that I last saw the deceased alive on 1/17/57 , 19____, and that death occurred at 11:00 M., from the causes and on the date stated above. Ernest I. Decko, M.D. Owings Mills, Md. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Richard Lindenberg</i>				PHYSICIAN'S NAME (Type) Richard Lindenberg, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-1-1				22b. DATE THEREOF 1-1-1		22c. NAME OF CEMETERY OR CREMATORY 1-1-1	
23. FUNERAL DIRECTOR'S SIGNATURE 1-1-1				ADDRESS 1-1-1		24a. REC'D BY REGISTRAR DATE: 21 1957	
24b. REGISTRAR'S SIGNATURE <i>Mary Elise</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Page 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

JAN 21 1957

RECEIVED

289

CERTIFICATE OF DEATH

Reg. Dist. No.

00276

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines 16 Rusting Ave		d. STREET ADDRESS 25 Holmhurst Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Roys Humphrey		4. DATE OF DEATH Month Day Year Jan. 13, 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ins. & Real Estate		10b. KIND OF BUSINESS OR INDUSTRY O.B.	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E.D. Humphrey		14. MOTHER'S MAIDEN NAME Martha Beckwith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs John LaVeck, 25 Holmhurst Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease DUE TO with cerebral degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Jan 12 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 8 , 19 54 , to Jan 13 , 19 57 , that I last saw the deceased alive on Jan 12 , 19 57 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Nesbitt Jr. M.D. 1118 St Paul St		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR.		Baltimore 2 Ind	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Jan. 14/57	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Great Barrington Mass.
23. FUNERAL DIRECTOR'S SIGNATURE Harvey A. White		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR Jan 15 57		24b. REGISTRAR'S SIGNATURE Robert Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JAN 16 1957

RECEIVED

207

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALETHORPE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4607 RIDGE AVE.</u>				e. STREET ADDRESS <u>4607 RIDGE</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES WILLIAM ISAAC</u>				4. DATE OF DEATH <u>JAN 14, 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 23, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER BLDG. SUPPLIES</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>AUGUSTUS ISAAC</u>			
14. MOTHER'S MAIDEN NAME <u>BESSIE RINEHART</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO <u>218-12-4023</u>				17. INFORMANT <u>MRS. CLOROM ISAAC 4607 RIDGE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma left kidney</u> 100X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Secondary metastases - Pancreas - 5 Keel</u> DUE TO (c) <u>He had been - leukemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7</u> <u>Nov - 56</u> <u>1956</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1956, to <u>Jan 14</u> , 1957, that I last saw the deceased alive on <u>Jan 14</u> , 1957, and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederic V. Reither</u>				ADDRESS (Street, city or town, state) <u>M.D. 1014 Francis Ave - Balto 21 - Md</u>			
PHYSICIAN'S NAME (Type) <u>FREDERIC V. REITHER</u>				DATE SIGNED <u>Jan 4 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1/17/1957</u>		<u>MEADOWRIDGE MEM</u>		<u>WASH. BLVD & DORSEY RD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Ave</u>				ADDRESS <u>CATONSVILLE, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 15 57</u>	
24b. REGISTRAR'S SIGNATURE <u>He Kuyfcar</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 10

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>13407</u>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>OLIVER</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-03</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>meat cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat business</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALGERNON JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. GRIMSLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>919-27-8687</u>	
17. INFORMANT <u>Hospital records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>56</u> , to <u>1-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William Newcomer</u> M.D.		PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D. Supt.</u> <u>Mt. Wilson, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN 4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. E. Bush</u>		ADDRESS <u>13407</u>	
24a. REC'D BY REGISTRAR <u>Jan 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 9 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

Walter R. Johnson

2. DATE
OF
DEATH

1/5/57

3. PLACE OF DEATH

A Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

before admission

B. FULL NAME OF (If not in hospital or institution, give street address or location)

5228 Old Frederick Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5228 Old Frederick Rd.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7/31/85

9. AGE (In years, last birthday)

71

10. Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Wm T. Johnson

14. MOTHER'S MAIDEN NAME

Ida Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

ADDRESS

Catherine A. Johnson (Wife)

Same

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Congestive Failure

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

4-2-1 ANTECEDENT CAUSES

(B) DUE TO

Arterio-Sclerotic C-V. Dis

?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(C) DUE TO

Diabetes

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-10-1956 to 1/5-1957, that (I) (we) last saw the deceased alive on 1/5-1957, and that death occurred at 12:45 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

M.D.

Catonsville, Md.

1/7/57

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/9/57

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Jan 9, 1957 W. H. Hedrick, 130 E. Red Ave

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and let HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

The

BUREAU V. S.

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00280**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 22 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 307 Oak Forest Avenue				d. STREET ADDRESS 307 Oak Forest Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last MIRIAM C. JONES				4. DATE OF DEATH Month Day Year January 29 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1908.		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enoch Hill Crosby				14. MOTHER'S MAIDEN NAME Ida P. Rhodes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT C. Kenneth Jones		Address 307 Oak Forest Ave. Catonsville 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Intoxication 270.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overdose of Barbiturate			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 1/29 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Catonsville Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt</i> EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF Feb. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Chicopee Falls, Hamden Co. Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Coston Sons</i>				ADDRESS Catonsville 28 Md		24a. REC'D BY REGISTRAR DATE FEB 4 '57	
				24. REGISTRAR'S SIGNATURE <i>W. H. Houch</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 4 1957

BUREAU A 2

293 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>713 S. Bond Street</u>	
3. NAME OF DECEASED (Type or print) First <u>MARION</u> Middle <u>J.</u> Last <u>KACZYNSKI</u>		4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1957</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/30/07</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kaczynski</u>		14. MOTHER'S MAIDEN NAME <u>Constance M. Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>1941-42</u>		16. SOCIAL SECURITY NO. <u>218-14-9336</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF LIVER</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 3, 1957</u> , to <u>January 5, 1957</u> , that I last saw the deceased alive on <u>January 5, 1957</u> , and that death occurred at <u>2:55 P.M.</u> , from the causes and on the date stated above			
ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u> DATE SIGNED <u>1/11/57</u>			
ACTUAL SIGNATURE <u>Polando Ponce de Leon</u> M.D.		DATE SIGNED <u>1/11/57</u>	
PHYSICIAN'S NAME (Type) <u>ROLANDO PONCE DE LEON, M.D.</u>		VAH, Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edgemoor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Palkowski</u>		ADDRESS <u>2007 Eastern Avenue, Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>8</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

11 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

291

CERTIFICATE OF DEATH

002823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>Valley Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ralph Frederick Kelbaugh</u>		4. DATE OF DEATH Month Day Year <u>January 28, 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/37</u>
9. AGE (In years last birthday) <u>19</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Marr Kelbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Audrey Virginia Damast</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of left jugular vein and sinus</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to acute abscess of sphenoid sinus.</u> DUE TO (c) <u>Aspiration bronchopneumonia.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Birth injury of brain.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 18, 19 57</u> , to <u>January 28, 19 57</u> , that I last saw the deceased alive on <u>January 28, 19 57</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ellis S. Margolin</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1/29/57</u>	
PHYSICIAN'S NAME (Type) <u>Ellis Margolin, Pathologist</u> <u>Springfield St. Hosp., Sykesville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-4-57</u>	<u>David Ridge Cem.</u>	<u>Pikeville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Garley Funeral Home - Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STAN V. S.

1957

RECEIVED

295

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 421 S. Conklin Street			
3. NAME OF DECEASED (Type or print) First ROBERT Middle C. Last KIBLER				4. DATE OF DEATH Month January Day 26 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/14		9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Luray, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Oscar M. Kibler			
14. MOTHER'S MAIDEN NAME Mary Martin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II			
16. SOCIAL SECURITY NO. 579 01 3685				17. INFORMANT Address Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IDIOPATHIC PURPURA 296X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from January 25, 1957 , to January 26, 1957 , that I last saw the deceased 8:50 P.M. and that death occurred at 8:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland		DATE SIGNED 1/28/57	
NAME (Type) DONALD D. MARK, M.D.				ADDRESS VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-57		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cemetery		22d. LOCATION (City, town, or county) (State) North East, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.				ADDRESS 6009 Harford Rd. Balto, Md.		24a. REC'D BY REGISTRAR DATE 1-30-57	
24b. REGISTRAR'S SIGNATURE Dawson L. Farley							

Shipped to: Joseph Grant Funeral Home, North East, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

208 CERTIFICATE OF DEATH

Reg. Dist. No.

00285

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4205 Wilkens Ave</u>			d. STREET ADDRESS <u>1 4205 Wilkens Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>M.</u> Last <u>Kinker</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1891</u>		9. AGE (In years last birthday) <u>65</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician, Riggs Distler Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christopher M. Kinker</u>			14. MOTHER'S MAIDEN NAME <u>Christine Arentz</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Jennie Kinker, 4205 Wilkens Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung & Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1 4205 Wilkens Ave</u>	
20f. (City or town) <u>Baltimore</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> to <u>1/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/5/57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John E. Healy</u> M.D.		ADDRESS (Street, city or town, state) <u>1717 N. ...</u> DATE SIGNED <u>1/7/57</u>			
PHYSICIAN'S NAME (Type) <u>John E. Healy</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>	
22d. LOCATION (City, town, or county) <u>Baltimore</u>		22e. (State) <u>Maryland</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. ...</u>		ADDRESS <u>101 ...</u>		24. REC'D BY REGISTRAR <u>JAN 9 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Geo S. M. ...</u>					

BUREAU V. S.

1 JAN 9 1957

RECEIVED

297

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consul				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consul (Balto Zone 27)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4431 Walnut Road				d. STREET ADDRESS 4431 Walnut Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIAM KLEBE				4. DATE OF DEATH Month Day Year Sat. Jan. 26, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Machine Shop Helper		10b. KIND OF BUSINESS OR INDUSTRY Shipyard Mach. Sh. Repairing		11. BIRTHPLACE (State or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Klebe				14. MOTHER'S MAIDEN NAME Mary (?)			
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Mary B. Klebe (Wife), Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Baltimore City, Md.		(County) (State)	
21. I certify that I attended the deceased from Dec 15 , 19 56 to Jan 26 , 19 57 , that I last saw the deceased alive on Jan 26 , 19 57 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2301 Annapolis Rd DATE SIGNED Dr. G. M. Kieffer							
ACTUAL SIGNATURE Paul Schufeldt M.D.				PHYSICIAN'S NAME (Type) Paul Schufeldt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 29 57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. HOWARD EVANS				ADDRESS 1400 d. Charles St. Balto 30 Md		24a. REC'D BY REGISTRAR DATE 1-28-57	
				24b. REGISTRAR'S SIGNATURE Dr. G. M. Kieffer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 29 1957

RECEIVED

CERTIFICATE OF DEATH

38

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

BUREAU V. S.

JAN 13 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00288

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u> LENGTH OF STAY (in this place) <u>40 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cherry Hill Road</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u> STREET ADDRESS (If rural give location) <u>Cherry Hill Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Anna Louise Korman</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 10 19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Apr 20 1898</u>		9. AGE last birthday <u>58</u> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wm Brothers</u>				14. MOTHER'S MAIDEN NAME <u>Ida May Beaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Geo W Korman Reisterstown Md</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>September 19 1957</u> to <u>January 10 1957</u> that I last saw the deceased alive on <u>Jan 3 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Clarence E. McWilliam</u> M.D.				ADDRESS (Street, city, town, state) <u>Reisterstown Maryland</u>			
DATE SIGNED <u>January 11 1957</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 13 1957</u>		NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>	
24. REC'D BY REGISTRAR DATE <u>1-10-57</u>		REGISTRAR'S SIGNATURE <u>Mary B. Ziege</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Berryman</u>		ADDRESS <u>Reisterstown</u>	

POWELL A. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00289 30
Reg. Dist. No.

300

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mth9dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Kortz Last Kortz		4. DATE OF DEATH Month January Day 29 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1887 69 yrs.
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired roofer	
10b. KIND OF BUSINESS OR INDUSTRY For Self		11. BIRTHPLACE (State or foreign country) Yugoslavia	
12. CITIZEN OF WHAT COUNTRY? Yugoslavia		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerotic cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 20 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19, 19 56 to Jan. 29, 19 57 , that I last saw the deceased alive on Jan 29, 19 57 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Jerome E. Shapiro, M.D. SPRING GROVE STATE HOSPITAL 1-29-57			
ACTUAL SIGNATURE Jerome E. Shapiro, M.D.		PHYSICIAN'S NAME (Type) Jerome E. Shapiro, M. D. Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/1/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	22d. LOCATION (City, town, or county) (State) 2930 Frederick Ave
23. FUNERAL DIRECTOR'S SIGNATURE John G. Cowan		24a. REC'D BY REGISTRAR 1-29-57	24b. REGISTRAR'S SIGNATURE A. J. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 20 1957

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00290

CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Balto.</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Baltimore</i>		<i>2 yrs</i>		TOWN <i>Balto.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Kidney Major Home</i>				STREET ADDRESS (If rural give location) <i>4702 Delaware Ave.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Selma Kreis</i>				<i>Jan 6, 1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M.</i>	8. DATE OF BIRTH <i>7-22-1876</i>	9. AGE last birthday <i>80</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Warrenton, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Williams</i>				14. MOTHER'S MAIDEN NAME <i>Largie Sledge</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr. John D. Moore 757 Blk. 1000</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <i>Thrombosis, cerebral</i>				<i>48 hours</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardiovascular Disease</i>				<i>5 years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <i>Osteoarthritis generalized severe</i>				<i>15 years</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-21-56</i> , to <i>Jan 6, 1957</i> , that I last saw the deceased alive on <i>Jan 6, 1957</i> , and that death occurred at <i>2:20 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>John F. Schaeffer</i>				ADDRESS (Street, city, town, state) <i>401 Random Road - Balto. 29-Md. 118157</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-9-57</i>		NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>		LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Overbach</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Foring Byers</i>		ADDRESS <i>5005 Pk. Hyattsville Balto 15, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

JAN 9 1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

302

CERTIFICATE OF DEATH

00291

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>Adm. 7/30/52</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMORY</u> First Middle <u>KUSZMAU</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/6/36</u>	
9. AGE (In years lost birthday) <u>20</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Emory Kuszman</u>				14. MOTHER'S MAIDEN NAME <u>Viola May Younger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Father 3319 Liberty Heights Baltimore Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) <u>Cerebral Spastic Quadriplegia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/21</u> 19 <u>57</u> , to <u>1/28</u> 19 <u>57</u> , that I last saw the deceased alive on <u>1/28/57</u> , 19 <u>57</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest J. Decker</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>ROSEWOOD, Owings, Md 1/28/57</u>			
PHYSICIAN'S NAME (Type) <u>Ernest J. Decker</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stacy Funeral Home</u>				24a. REC'D BY REGISTRAR <u>1-19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>	

RECEIVED
JAN 30 1957
BUREAU W. F.

0303

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Delaware b. COUNTY Sussex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS Route #2			
3. NAME OF DECEASED (Type or print) First DANIEL Middle B. Last LANGRALL				4. DATE OF DEATH Month January Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1910		9. AGE (In years last birthday) yrs 46	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Shipping Company		11. BIRTHPLACE (State or foreign country) Oxford, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James F.H. Langrall				14. MOTHER'S MAIDEN NAME Margaret L. Bridges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Administration Hospital, Ft. Howard			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF LEFT TEMPORAL LOBE 302 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 4 , 19 57 , to January 11 , 19 57 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rolando D. Ponce de Leon				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 1/11/57	
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-12-57		22c. NAME OF CEMETERY OR CREMATORY Landing Neck Cemetery		22d. LOCATION (City, town, or county) (State) Trappe, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight, Inc.				24a. REC'D BY REGISTRAR JAN 25 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Fairer	
25. FUNERAL HOME Ronald James Funeral Home, Millsboro, Delaware							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 19 1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00293

Reg. Dist. No.

37

0304

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. STREET ADDRESS <u>CHURCH LAKE</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>LONG</u> Middle <u>LONG</u> Last				4. DATE OF DEATH <u>1</u> Month <u>41</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-12-01</u>	9. AGE (In years last birthday) <u>55 1/2</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTINENTAL CANCO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM LONG</u>				14. MOTHER'S MAIDEN NAME <u>THERESA TENTEROUGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, for how long) <u>NO</u>		16. SOCIAL SECURITY NO. <u>210-69558</u>		17. INFORMANT <u>Hospital records, Mt. Wilson State Hospital</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>FAR ADVANCED PULMONARY TBC.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>12.29.55-1.21.57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>12-29</u> , 19 <u>55</u> to <u>1-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-21-57</u> , and that death occurred at <u>11</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Newcomer</u> M.D.				ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u> ADDRESS <u>622 York Rd., Towson 4, Md</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Sarah Newell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

14N 0 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

305 CERTIFICATE OF DEATH

00294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home 5743 Edmondson Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 Vol. 4 Baltimore STREET ADDRESS 3313 Liberty Heights Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Barbara Lorfing		4. DATE OF DEATH Month Day Year Jan. 30/57 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Dec. 5, 1897
9. AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Adam Bicask		14. MOTHER'S MAIDEN NAME Eve---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Otto Lorfing		Address 3313 Liberty Heights Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (glio blastoma) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH approx. 4 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. s. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-28 , 19 58 , to 1-30 , 19 57 , that I last saw the deceased alive on 1-28 , 19 57 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stanley R Steinbach		ADDRESS (Street, city or town, state) 3334 Dolford Ave	
PHYSICIAN'S NAME (Type) STANLEY R. STEINBACH		DATE SIGNED Baltimore 15, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Jan. 30/57	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Kansas City, Kansas
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke		24a. REC'D BY REGISTRAR Jan 31 57 DATE	
ADDRESS 4101 Edmondson Ave		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG239 1-1-57 at

CERTIFICATE OF DEATH

Reg. Dist. No.

00295

306

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME</u>				e. STREET ADDRESS <u>114 LAUREL AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>COL FAX</u> Middle <u>LOWE</u> Last <u>LOWE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>19 57</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-3-1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>YORK CO., PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>OSCAR LOWE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ANN KING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Wm. Villard, Catonsville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Coronary arterio sclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>and more</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>Jan 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>57</u> , and that death occurred at <u>2:52</u> P. M.; from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>4605 Edmonson ave</u>			
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>				DATE SIGNED <u>1/4/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends</u>		22d. LOCATION (City, town, or county) (State) <u>Friends York Co., Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Lushbaugh</u>				ADDRESS <u>3100 S. State St. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-8-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Cliff Ratliff</u>							

BUREAU V. S.

APR 7 1957

RECEIVED

197

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>6752 Woodley Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Leola E. Saffy</u>				4. DATE OF DEATH <u>Jan 30 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 4 1884</u>	
9. AGE (In years for birthday) <u>72</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret</u>		11. BIRTHPLACE (State or foreign country) <u>Pu</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Leola E. Saffy</u>		14. MOTHER'S MAIDEN NAME <u>Doris K. Saffy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>		17. INFORMANT <u>Mr. Max Saffy, 6752 Woodley Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO <u>Cancer Prostate gland</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 yrs.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>57</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>David H. Andrew</u> M.D.				ADDRESS (Street, city or town, state) <u>33 Dundalk Ave.</u>			
PHYSICIAN'S NAME (Type) <u>David H. Andrew M.D.</u>				DATE SIGNED <u>Dundalk Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 31 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burn Creek</u>		22d. LOCATION (City, town, or county) (State) <u>New Kensington Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u>				ADDRESS <u>2112 Dundalk</u>		24a. REC'D BY REGISTRAR <u>Mr. Kelly</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>FEB 1 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low require that the death certificate be examined within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00297

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>34 Hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 McCann Ave.</u>		d. STREET ADDRESS <u>1200 E Balto St</u>	
3. NAME OF DECEASED (Type or print) <u>LeLands Stantord Lynch</u>		4. DATE OF DEATH <u>January 21 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Painter - Self Emp. Painting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Constantine Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Mary Winters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>218-01-7024</u>	
17. INFORMANT <u>Mr. Frederick C. Lynch - Box 166, Belair, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 1X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto. 17 Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Jan 25 1957</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Chilcote</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

308

CERTIFICATE OF DEATH

Reg. Dist. No. 00298 37

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Falls Road				e. STREET ADDRESS Falls Road			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle ELIZABETH Last MAINZ				4. DATE OF DEATH Month Jan. Day 11 Year 1957			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Isaac S. Crowther				14. MOTHER'S MAIDEN NAME Georgianna Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Lola M. Tinsley - 5219 Wilton Hgts. Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocarditis - chronic 44 DUE TO hypertension - decompensated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) general arteriosclerosis - marked (c) 50 or more years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) years						INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ✓ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1-1956 to 1-11-1957 , that I last saw the deceased alive on 1-10-1957 , and that death occurred at 5 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James S. Saffell				ADDRESS (Street, city or town, state) Reisterstown Md		DATE SIGNED 1-14-57	
PHYSICIAN'S NAME (Type) James S. Saffell				M.D. Reisterstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Schaefer & Sons - Balt 17 Md				ADDRESS Balt 17 Md		24a. REC'D BY REGISTRAR DATE 1/15/57	
				24b. REGISTRAR'S SIGNATURE H. H. Hedrick			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 16 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

198

CERTIFICATE OF DEATH

00299

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>523 New Pittsburg Ave.</u>		STREET ADDRESS (If rural, give location) <u>523 New Pittsburg Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ernest</u> (Middle) <u>Lester</u> (Last) <u>McClary</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>16 May 1910</u>
9. AGE last birthday <u>46</u> yrs.		10. If under 1 year: Months <u>9</u> Days <u>3</u> Hours <u>2</u> Mins. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Salters, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Prince McClary</u>		14. MOTHER'S MARDEN NAME <u>Margatha</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>224-07-7859</u>	
17. INFORMANT AND ADDRESS <u>Minnie L. McClary 523 New Pittsburg Ave #22</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Broncho-pneumonia</u>			<u>2 days</u>
Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u></u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-23-</u> , 19 <u>57</u> , to <u>1-24-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-24-</u> , 19 <u>57</u> , and that death occurred at <u>12:25</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>William C. Hale M.D.</u>		ADDRESS <u>1400 Mt. Ave. Dundalk 22 Md.</u>	
DATE SIGNED <u>1-24-57</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>1/28/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR		ADDRESS	
Charles R. Law		802 Madison Avenue	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 29 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00300

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9909 Finney Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marian Middle L. Last McCleary				4. DATE OF DEATH Month January Day 25 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1923 Feb-24-1923	9. AGE (In years last birthday) 33 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cafeteria		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Isennock				14. MOTHER'S MAIDEN NAME Neva Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-3512		17. INFORMANT Address James L. McCleary (same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of abdomen DUE TO (b) 110X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in abdomen
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 1/25/ 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas F. Evans & Son 8802 Harford Rd.				24a. REC'D BY REGISTRAR DATE 29 1957		24b. REGISTRAR'S SIGNATURE Dr. A. M. B...	

BUREAU V. S.

JAN 28 1957

RECEIVED
JAN 28 1957

310 **CERTIFICATE OF DEATH**

00301

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>5 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis (Winchester on Severn)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Rt 4 Box 161</u>			
3. NAME OF DECEASED (Type or Print) <u>LEILA MAY MCGILLIVRAY</u>				4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>31</u> (Year) <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 9, 1872</u>	9. AGE last birthday <u>84 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elisha Turner Sentell</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Condon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mr Archie McGillivray-Son- same as # 2</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
<u>1122.1</u> IMMEDIATE CAUSE (A) <u>Cerebral thromboses</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ASCVD, grade III</u>				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Unknown</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 20, 19 52</u> , to <u>Jan 31, 19 57</u> , that I last saw the deceased alive on <u>Jan 30, 19 57</u> , and that death occurred at <u>2:07</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Higgins</u>		M.D. <u>908 Catonsville Rd</u>		DATE SIGNED <u>1-31-57</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial-Removal</u>		DATE THEREOF <u>Feb. 2, 57</u>		NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Birmingham, Alabama</u>	
24. REC'D BY REGISTRAR <u>W. H. Beach</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Beach</u>			
DATE <u>FEB 4 '57</u>				ADDRESS <u>Annapolis, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

FEB 7 1957

RECEIVED

311

CERTIFICATE OF DEATH

Reg. Dist. No.

35-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White 1</u> c. LENGTH OF STAY IN 1b <u>23 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>White 1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White 1</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frederic</u> Middle <u>Zeneth</u> Last <u>McGinnis</u>				4. DATE OF DEATH Jan. <u>14</u> 19 <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1868</u>		9. AGE (In years last birthday) <u>88</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-11-57</u>		17. INFORMANT <u>Stewart</u> Address <u>Stewart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis advanced</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>15 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>June, 1950</u> , to <u>1-6-1957</u> , that I last saw the deceased alive on <u>1-6-1957</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>William O. Fulton</u> M.D. <u>Stewart</u> ADDRESS (Street, city or town, state) <u>Stewart</u> DATE SIGNED <u>1-9-57</u> PHYSICIAN'S NAME (Type) <u>William O. Fulton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Central</u>			
22d. LOCATION (City, town, or county)		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Coleman</u>		ADDRESS <u>Stewart</u>		24a. REC'D BY REGISTRAR <u>1/16/57</u>			
24b. REGISTRAR'S SIGNATURE <u>William O. Fulton</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 15 1907

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth4dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown, Maryland	
3. NAME OF DECEASED (Type or print) First John Middle J. Last McGuire		4. DATE OF DEATH Month January Day 9, Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 69 1/2 yrs.		10. IF UNDER 1 YEAR Months 6 Days 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stock accountant		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Ireland?		12. CITIZEN OF WHAT COUNTRY? U. S. A.?	
13. FATHER'S NAME John McGuire		14. MOTHER'S MAIDEN NAME Mary McGuire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary thrombosis and infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right hip INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pt. slipped in tub while bathing, sustaining frac. right femur.	
20c. TIME OF INJURY Month, Day, Year 10:00 a.m. 12-28 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>George M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57	
22c. NAME OF CEMETERY OR CREMATORY Backus Memorial		22d. LOCATION (City, town, or county) (State) Interden Hart	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Stanger</i>		ADDRESS 1315 Light St.	
24a. REC'D BY REGISTRAR Jan 15 57		24b. REGISTRAR'S SIGNATURE <i>Arthur</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 1 1957
U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

199

CERTIFICATE OF DEATH

Reg. Dist. No.

00304

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 55 Broadship Road		d. STREET ADDRESS 53 Broadship	
3. NAME OF DECEASED (Type or print) J Clyde McIntire		4. DATE OF DEATH Jan 5/56 Day Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done for most of working life, even if retired) Neural Metallurgist		10b. KIND OF BUSINESS OR INDUSTRY Beth Steel	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Mc Intire		14. MOTHER'S MAIDEN NAME Lucy Goode	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Violet McIntire 53 Broadship		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 440.1			INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2-3 YRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19- , 19 56 , to 12-31- , 19 56 , that I last saw the deceased alive on 12-31-56 , 19 56 , and that death occurred at 1:45 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W E Baermann		M.D. DR. W. E. BAERMANN ADDRESS (Street, city or town, state) 33 DUNDALK AVENUE DUNDALK 22, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Jan 5/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral 2112 Dundalk Ave		24a. REG'D BY REGISTRAR JAN 8 1957	
24b. REGISTRAR'S SIGNATURE <i>Mr. M. Kelly</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. E.

MAR 3 1957

RECEIVED

313

CERTIFICATE OF DEATH

00305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>New Orleans</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard-Enoch Pratt Hosp.</u>				d. STREET ADDRESS <u>7327 Sycamore St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora McGloin McLoughlin</u>				4. DATE OF DEATH Month Day Year <u>1 31 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank McGloin</u>				14. MOTHER'S MAIDEN NAME <u>Alice Kleinpeter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Frank McLoughlin 3004 Coliseum St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic Depressive Psychosis, Mixed Type</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> 19 p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				(County) <u>—</u>		(State) <u>—</u>	
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>37</u> , to <u>1-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.W. Elgin</u>				ADDRESS (Street, city or town, state) <u>Sheppard Pratt Hosp.</u>			
PHYSICIAN'S NAME (Type) <u>W.W. Elgin</u>				DATE SIGNED <u>1/31/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cem. #3</u>		22d. LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto</u>				24. REC'D BY REGISTRAR <u>EB 1</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

BUREAU V. S.

APR 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00306
20

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY 	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5mth23dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
f. STREET ADDRESS 1012 Forrest St. * Balto. 2, Md.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daisy O McQuay		4. DATE OF DEATH Month January Day 7 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 19 1885 unknown
9. AGE (In years last birthday) 71 3/4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife (Pecker)		10b. KIND OF BUSINESS OR INDUSTRY McCormick & Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknownx Gustavus Jones		14. MOTHER'S MAIDEN NAME unknown Sutton Hunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor. active heart failure DUE TO hypertension Conditions, if any, which gave rise to immediate cause (b) Pending (c) associated with cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) pt. fell on 12-27-56 sustaining laceration of forehead on right side.	
20c. TIME OF INJURY Month, Day, Year 5:00 p.m. 12-27-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. M. Kieffer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-57	
22c. NAME OF CEMETERY OR CREMATORY Moreland		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE 1/10/57	
		24b. REGISTRAR'S SIGNATURE R. H. Hedrick	

DATE SIGNED

Jan 8 57

BUREAU V. B.

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7, 2-1-57 et

CERTIFICATE OF DEATH

00307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville - 28 -</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>A</u> Last <u>MEEHAN</u>		4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1882</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labour</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Michael Meehan</u>		14. MOTHER'S M maiden name <u>Elizabeth Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Mary Meehan</u> Address <u>14 Ridge Rd 28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory failure.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Atherosclerosis, generalized, severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10 Jan 1957</u> to <u>23 Jan 1957</u> , that I last saw the deceased alive on <u>23 Jan 1957</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED.			
ACTUAL SIGNATURE <u>William J. Bryson</u> M.D.		DATE SIGNED <u>25 Jan 1957</u>	
PHYSICIAN'S NAME (Type) <u>William J. Bryson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <input checked="" type="checkbox"/>	22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge City - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Robert S. Catonsville - 18 - MD</u>		24a. REC'D BY REGISTRAR <u>128 57</u>	24b. REGISTRAR'S SIGNATURE <u>Al Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BUREAU V. S.

No.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 1-16-57

00308

316

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Havre de Grace</u> c. LENGTH OF STAY IN 1b <u>6 M.O.S.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>474 Chesapeake Dr. Baltimore Maryland</u>			
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>HERMAN</u> Last <u>Meyer</u>				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-16-1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Otto Meyer</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Samsel</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>Harold Meyers</u> Address <u>Grace 707</u> <u>974 Chesapeake Dr. Havre de</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4:20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardio vascular disease</u> DUE TO (c) <u>Indeterminate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 3, 1955</u> , to <u>January 13, 1957</u> , that I last saw the deceased alive on <u>January 13, 1957</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Ward</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove Hosp. 1/13/57</u>			
PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SYRACUSE, ONONDAGA, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>K. Madison Mitchell</u>				ADDRESS <u>Harold Grace M.O.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 16 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. ...</u>							

RECEIVED

JAN 16 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8mth25dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Freeman Last Miller		4. DATE OF DEATH Month January Day 19 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1874
9. AGE (in years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired minister		10b. KIND OF BUSINESS OR INDUSTRY Alabama	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Miller		14. MOTHER'S MAIDEN NAME Nancy Rerr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 450.0 DUE TO Generalized Arteriosclerotic disease Conditions, if any, which gave rise to immediate cause (b) 954.8 (c) fracture of left femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture of left femur INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) discovered to have fracture of left femur. No one knows how injury occurred.	
20c. TIME OF INJURY Month, Day, Year Hour 12:00 m. 11-30-56		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 19. 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-21-57	22c. NAME OF CEMETERY OR CREMATORY St Annes	22d. LOCATION (City, town, or county) (State) Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE John M. Teyler Sons		24a. REC'D BY REGISTRAR DATE 1/21/57	
ADDRESS Annapolis Md		24b. REGISTRAR'S SIGNATURE J. Daniel	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 1957
BUREAU V. S.

318 CERTIFICATE OF DEATH

Reg. Dist. No.

45

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN 1b 5.4 Essex d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 BRANCH ST		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Branch St. Balto. 21 Md. d. STREET ADDRESS 10 Branch St. Balto. 21 Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Elizabeth Middle Mitchell Last Mitchell		4 DATE OF DEATH Month January Day 18 Year 19 57	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/1907 9 AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lee A. Kerr		14. MOTHER'S MAIDEN NAME Minnie Ely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Harry C. Mitchell		Address (same as above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia, chronic 602X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral calculus pyonephrosis. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19 47 , to Jan. 18 19 57 , that I last saw the deceased alive on Jan. 18 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ridge Road DATE SIGNED 1/18/57			
ACTUAL SIGNATURE Harvey L. Fuller M.D.		DATE SIGNED 1/18/57	
PHYSICIAN'S NAME (Type) HARVEY L. FULLER, M.D.		Baltimore 6, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1122157	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		ADDRESS Balto. 21 Md.	
24a. REC'D BY REGISTRAR JAN 22 1957		24b. REGISTRAR'S SIGNATURE Edith H. Huley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4208 Edmondson Avenue	
3. NAME OF DECEASED (Type or print) First Evie Middle Smith Last Montgomery		4. DATE OF DEATH Month January Day 20 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1869
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leon Smith		14. MOTHER'S MAIDEN NAME Molly ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records; SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1, 19 56 to Jan. 20, 19 57 , that I last saw the deceased alive on Jan. 20, 19 57 , and that death occurred at 8:20 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Louise Frances Woodward M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED Jan. 20, 19 57	
PHYSICIAN'S NAME (Type) Louise Frances Woodward		Catonsville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
transportation	1/21/57	Canton	Mississippi
23. FUNERAL DIRECTOR'S SIGNATURE T. Gasch, Son Hyattsville Md		24a. REC'D BY REGISTRAR DATE JAN 24 '57	24b. REGISTRAR'S SIGNATURE Reese

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

320

CERTIFICATE OF DEATH

00312

Reg. Dist. No. 33-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u>		d. STREET ADDRESS <u>'Old York Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Mooney</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22 1874</u>
9. AGE (In years, less birth day) <u>82</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>County Clare, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown.</u>		14. MOTHER'S MAIDEN NAME <u>Ann Neigent.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>John Heiser - White Hall, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerosis</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. g. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1/57</u> , 19 <u>57</u> , to <u>1/3/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/3/57</u> , 19 <u>57</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. M. France</u>		ADDRESS (Street, city or town, state) <u>PARKTON, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		DATE SIGNED <u>1/4/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hartenstein</u>		24a. REC'D BY REGISTRAR <u>Charles J. Friedman</u>	
ADDRESS <u>New Freedom, Pa.</u>		DATE <u>1/7/57</u>	

RECEIVED
JAN 10 1957
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00313

321

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stevenson Rd.</u>		e. STREET ADDRESS <u>Timber Grove Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1938</u>
9. AGE (In years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>15</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Franklin Murray Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn E. Rittenhouer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-34-1565</u>	
17. INFORMANT <u>William F. Murray, Owings Mills, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull, crushed chest, fracture of left shoulder and left femur due to auto accident.</u>			
DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck culvert.</u>	
20c. TIME OF INJURY Month, Day, Year <u>12 MN o. m. Jan. 12 19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stevenson Rd.,</u>		20f. (City or town) (County) (State) <u>Stevenson Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 15 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>		24a. REC'D BY REGISTRAR <u>Jan 15 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Sorathy Newell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter cause of death in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 10 1961

U.S. DEPARTMENT OF
THE ARMY
WASHINGTON, D.C.

1

CERTIFICATE OF DEATH

Reg. Dist. No. 41

200

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		STATE <u>MD</u> COUNTY <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>503 BAYSIDE Rd</u>		STREET ADDRESS (If rural give location) <u>503 BAYSIDE Rd</u>		LENGTH OF STAY (in this place) <u>14 YRS</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNA</u> (Middle) <u>BROWN</u> (Last) <u>WEBINGER</u>				(Month) <u>1-25-</u> (Day) <u>19</u> (Year) <u>57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOW</u>	8. DATE OF BIRTH <u>SEPT 8, 1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NOT RECORDED</u>		17. INFORMANT & ADDRESS <u>ROBT. WEBINGER - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A) <u>Hypertensive Cardio-Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>—</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 25, 1957</u> to <u>Jan 25, 1957</u> , that I last saw the deceased alive on <u>Jan 25, 1957</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. A. Evans</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-28-57</u>		NAME OF CEMETERY OR CREMATORY <u>EMANUEL</u>		LOCATION (City, town, or county) (State) <u>LEWISBERRY, PA</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Smith Headley, Dundalk MD</u>		ADDRESS	
DATE <u>JAN 28 1957</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
JAN 28 1957
BUREAU V. 3

322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville			
c. LENGTH OF STAY IN 1b 55 yrs				d. STREET ADDRESS 1333 Valleybrook Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1333 Valleybrook Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAUDE BELL NEELY				f. DATE OF DEATH Jan 30 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 8, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Lemuel Grice				14. MOTHER'S MAIDEN NAME Katherine Sherman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. —		17. INFORMANT Alfred J. Neely Address 1333 Valleybrook Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer - Carcinoma of colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 3 yrs, 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan - 30 - 1954 to Jan - 30 - 1957 , that I last saw the deceased alive on Jan - 30 - 1957 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Chambers M.D.				ADDRESS (Street, city or town, state) 4105 Liberty Pls in Balto Md DATE SIGNED 2/1/57			
PHYSICIAN'S NAME (Type) DR. EARL L. CHAMBERS				BALTIMORE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 2 - 1957		22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur F. Taylor ADDRESS 5311 Edmondson Ave				24a. REC'D BY REGISTRAR — DATE Feb 1 - 57		24b. REGISTRAR'S SIGNATURE —	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

323

CERTIFICATE OF DEATH

Reg. Dist. No. 0031644

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 99 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 1329 Park Avenue			
3. NAME OF DECEASED (Type or print) First DUDLEY Middle F. Last NICHOLSON				4. DATE OF DEATH Month January Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1892	
9. AGE (In years last birthday) yrs 64		IF UNDER 1 YEAR Months 04 Days 04 Hours 00 Min. 00		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Bank	
11. BIRTHPLACE (State or foreign country) Mt. Washington, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Edwin C. Nicholson				14. MOTHER'S MAIDEN NAME Camilla Dunkel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA, LEFT LUNG, WITH CEREBRAL METASTASES DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1956 , to January 8, 1957 , that death occurred at 1:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving Freeman				ADDRESS (Street, city or town, state) M.D. Veterans Administration Hospital			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland				DATE SIGNED 1/8/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-57		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart and Mowen Co., 108 W. North Ave., Balto. Md.				ADDRESS		24a. REC'D BY REGISTRAR 9 1957	
				24b. REGISTRAR'S SIGNATURE Lawson L. Larkins			

RECEIVED

JAN 9 1957

BUREAU V. 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

324

CERTIFICATE OF DEATH

00317

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 110 Schroeder Ave</u>		d. STREET ADDRESS <u>Box 110 Schroeder Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Kathleen V. Nickles</u>		4. DATE OF DEATH Month Day Year <u>January 8th 19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1932</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Marie Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Donald Edward Nickles, Sr.</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 2, 1957</u> , to <u>Jan 8, 1957</u> , that I last saw the deceased alive on <u>Jan 7, 1957</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>300 E. North Ave</u>			
ACTUAL SIGNATURE <u>Coral Gordon</u>		M.D. <u>300 E. North Ave</u>	
PHYSICIAN'S NAME (Type) <u>Coral Gordon</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/11/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hargord Road #14</u>	
24a. REC'D BY REGISTRAR <u>JAN 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. C. L. Reford</u>	

BUREAU Y. S.

JAN 10 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00318

325
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>412 Overbrook</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>412 Overbrook Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Edward</u> Last <u>Noone</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>19 57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Contractor, Noone Elet. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick T. Noone</u>		14. MOTHER'S MAIDEN NAME <u>Rosa M. Starry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-09-1578</u>	
(If yes, give war or dates of service)		17. INFORMANT <u>Mrs Wilhelmina Noone, 412 Overbrook Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Urinary Bladder</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>49</u> , to <u>January</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 5</u> , 19 <u>57</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Leo J. Gaver</u> M.D. <u>1 Mallow Hill Ave., Baltimore, Md. 1/7/57</u> PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>Jan. 9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witke</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>4101 Edmondson Ave</u>		DATE <u>JAN 9 '57</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

BUREAU V. S.

JAN 9 1957

RECEIVED

may be retained by the hospital, or attending physician, and completely filled out by the funeral director, to FURNISH TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Approved & countersigned John C. Nuth, Jr. 1-22-57. Balto. Co. (M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

326

CERTIFICATE OF DEATH

00319

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1803 Summit Avenue</u>				d. STREET ADDRESS <u>1803 Summit Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Master Bernard H Nuth 3rd.</u>				4. DATE OF DEATH Month Day Year <u>January 22, 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17, 1948</u>	
9. AGE (In years last birthday) <u>8 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard H. Nuth, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Marie C. Akelaitis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Bernard H. Nuth, Jr.</u>		Address <u>1803 Summit Ave #6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> <u>351x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-1-57</u> , 1957, to <u>JAN</u> , 1957, that I last saw the deceased alive on <u>1-20-57</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>James R. Mason M.D.</u>				M.D. <u>8019 Philadelphia Road</u>			
PHYSICIAN'S NAME (Type) <u>James R. Mason M.D.</u>				Baltimore 6, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 24 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurling</u>			

BUREAU V. A.

1957

Approved by Hyatt and
John P. Hyle. ml.
1-22-57

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>8yr6mth24dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSITAL</u>				e. STREET ADDRESS <u>1111 East 20th St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>R.</u> Last <u>O'Brien</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1892</u>	9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William G. O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Emma Airey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured esophagus</u> <u>100x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the esophagus with metastasies</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 27, 19 56</u> , to <u>Jan. 22, 19 57</u> , that I last saw the deceased alive on <u>Jan. 22, 19 57</u> , and that death occurred at <u>11:25am</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>1-22-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholickem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Funeral Home-Catonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 28 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 7 1957

BUREAU V. S.

328

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore,		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 28 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Towson		d. STREET ADDRESS 1001 West Joppa Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister Mary Ligouri, O'Brien		First Middle Last		4. DATE OF DEATH Month Day Year Jan. 24, 1957		19 19	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (State or foreign country) Dromada, Co. Cork, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bartholomew O'Brien		14. MOTHER'S MAIDEN NAME Mary Cosgrove					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Convent Records, 1001 W. Joppa Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Renal DUE TO Vascular Disease (c) 12 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 47 , to Jan. , 19 57 , that I last saw the deceased alive on Jan. , 19 57 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7501 York Road, Towson, Md.		DATE SIGNED 1/25/57			
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. 7501 York Road, Towson, Md.					
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell,		7501 York Road, Towson, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery,		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Vernon Lemmon		ADDRESS 4611 Park Hgts. Balto.		24a. REC'D BY REGISTRAR JAN 28 1957		24b. REGISTRAR'S SIGNATURE Nat'l Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00322

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Osborne Ave		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE MD b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville d. STREET ADDRESS 3 Osborne Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eleanor Bruce Oswald First Middle Last		4. DATE OF DEATH Month Jan. 16, 1957 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH may 13, 1894
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home	11. BIRTHPLACE (State or foreign country) Not known Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Wm. L. Bruce	
14. MOTHER'S MAIDEN NAME Not Known		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Bruce Oswald 3 Osborne Ave Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Robert M. Kieffer</i> EXAMINER'S NAME (Type) Robert M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jany. 16, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-19-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. ...</i> ADDRESS		24a. REC'D BY REGISTRAR DATE Jany 17 1957	
24b. REGISTRAR'S SIGNATURE <i>John J. ...</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **38**

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 14			c. LENGTH OF STAY IN lb 2yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Balto 14		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7840 Shepherd						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Herbert H Pannier				4. DATE OF DEATH Month Day Year Jan 4 19 57				
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 June 1890		
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retire transit worker				10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co		11. BIRTHPLACE (State or foreign country) Baltimore		
12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME ? Pannier				14. MOTHER'S MAIDEN NAME Sarah ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-10-0941		17. INFORMANT Address Nicholas Bassetti 7840 Shepherd Balto 14				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency Chronic DUE TO (c) Atherosclerosis, Generalized severe							INTERVAL BETWEEN ONSET AND DEATH Inst 5-6-yrs undet	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John C. Hyle</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John C Hyle MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-8-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE Jan. 7, 1957		24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>		

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

BUREAU V. B.

JUN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

00324

2411 N. Charles Street, Baltimore

331 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5009 Wilkens Ave.		STREET ADDRESS (If rural, give location) 5009 Wilkens Ave.	
3. NAME OF DECEASED (First) Anna (Middle) M. (Last) Patterson		4. DATE OF DEATH (Month) Jan. 9, (Day) 9, (Year) 1957	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Aug. 27, 1874
9. AGE last birthday 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel W. Patterson		14. MOTHER'S MAIDEN NAME Margaret Gillen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-09-1323A	
17. INFORMANT AND ADDRESS Mrs Margaret Oster, 5009 Wilkens Av			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Cardiac Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arterio-Sclerotic Cardiac Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/10, 1954, to 1-9, 1957, that I last saw the deceased alive on 1-9, 1957, and that death occurred at 7:50 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JAN 21 1957

RECEIVED

00325

232

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED
MAY 19 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00326

CERTIFICATE OF DEATH

Reg. Dist. No.

209

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus (English Consul) Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>English Consul</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2620 Daisy Ave</u>		d. STREET ADDRESS <u>2620 Daisy Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A.</u> Last <u>PETERSON</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>19 57</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/96</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Allen</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Diabetic Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3 yrs.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>422.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1, 1950</u> , to <u>1-20, 1957</u> , that I last saw the deceased alive on <u>1-20, 1957</u> , and that death occurred at <u>2:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>207 Fort Ave Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>1-21-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>		ADDRESS <u>130 E. Fort Ave.</u>	
24a. REC'D BY REGISTRAR <u>221</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled out by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00327

333

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 130 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2144 Aiken Street			
3. NAME OF DECEASED (Type or print) First EDWARD Middle Last PFAFF				4. DATE OF DEATH Month January Day 21 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bundler		10b. KIND OF BUSINESS OR INDUSTRY Box Factory		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Pfaff				14. MOTHER'S MAIDEN NAME Margaret Gintmann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO 315-10-5676		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEOPLASM, RIGHT ADRENAL GLAND, WITH METASTASIS TO LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 42						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 13, 1956 , to January 21, 1957 , and that death occurred at 5:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 1/21/57							
ACTUAL SIGNATURE Rolando D. Ponce de Leon		M.D. Veterans Administration Hospital					
PHYSICIAN'S NAME (Type) ROLANDO D. PONCE de LEON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc ADDRESS Wm Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md				24a. REC'D BY REGISTRAR JAN 25 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

THE NEW YORK

1937

THE NEW YORK

334

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 30 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD PFEFFER		4. DATE OF DEATH 1-16-57	
5. SEX MA	6. COLOR OR RACE WHI	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 3-1870
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY BALTO MD	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIMON PFEFFER		14. MOTHER'S MAIDEN NAME JULIANA SCHAEFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ✓	
17. INFORMANT MRS CHAS WALASCHMIET		Address 38 CVERBROOK Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 442X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1957 to 16 Jan 1957 that I last saw the deceased alive on 15 Jan 1957 , and that death occurred at 4:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St Baltimore 2 Ind DATE SIGNED			
ACTUAL SIGNATURE John A. Leimbach M.D.		PHYSICIAN'S NAME (Type) John A. Leimbach	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/57	
22c. NAME OF CEMETERY OR CREMATORY LOUWON PARK		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE GEO H LEIMBACH ADDRESS 525 N. LYNDA HURST		24a. REC'D BY REGISTRAR Jan 16 57 24b. REGISTRAR'S SIGNATURE John A. Leimbach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 17 1937

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00329
38

335 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN lb 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3 years 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ARMACOST NURSING HOME				d. STREET ADDRESS 1208 SOUTHVIEW ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELISE MARIE PITZ				4. DATE OF DEATH Month Day Year JAN. 16, 1957 19			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK PITZ				14. MOTHER'S MAIDEN NAME EMMA MEISTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT GEORGE STURMFELSZ		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/24/36 to 1/16/57 , that I last saw the deceased alive on 1/16/57 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Walter E. Karfagin 4331 Harbor Rd DATE SIGNED ACTUAL SIGNATURE WALTER E. KARFAGIN, M.D. PHYSICIAN'S NAME (Type) WALTER E. KARFAGIN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/57		22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.				24a. REC'D BY REGISTRAR Jan 21 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

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JAN 21 1957

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 52 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00330

Reg. Dist. No.

210

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne				c. LENGTH OF STAY IN lb 4 1/2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 2515 Hammonds Ferry Road				e. STREET ADDRESS 2515 Hammonds Ferry Road			
3. NAME OF DECEASED (Type or print) William Burgess Pollhein				4. DATE OF DEATH Month January Day 30 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1888	9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months 30 Days 19 Hours 57		IF UNDER 24 HRS. Months 30 Days 19 Hours 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (ret.)				10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO 216 09 0806				17. INFORMANT Address Mrs. Edith E. Pollhein Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease with Coronary Insufficiency 4 : : DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) : : DUE TO (c) : : DUE TO						INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 30, 1953 , to Jan. 30, 1957 , that I last saw the deceased alive on Dec. 8, 1956 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Arthur Rosenberg M.D.				ADDRESS (Street, city or town, state) 2436 Washington Blvd.			
PHYSICIAN'S NAME (Type) C. ARTHUR ROSENBERG M.D.				DATE SIGNED Baltimore 30 Feb.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 2/57		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Cecil Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard L. Elton				24a. REC'D BY REGISTRAR Feb 4 1957		24b. REGISTRAR'S SIGNATURE Dr. J. M. Lippert	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00331

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gores Mill Rd.		d. STREET ADDRESS Gores Mill Rd.	
3. NAME OF DECEASED (Type or print) Ernest Campbell Popplein		4. DATE OF DEATH Jan. 6, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1883
9. AGE (In years, last birthday) 73 yrs		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John T. Popplein		14. MOTHER'S MAIDEN NAME Matelda Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mary R. Popplein, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from Feb. 9, 1937 to Jan. 6, 1957 , that I last saw the deceased alive on Dec. 28, 1956 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. D. Caples		ADDRESS (Street, city or town, state) 6 Hanover Rd.,	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		DATE SIGNED 1-7-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 1-7-57	
24b. REGISTRAR'S SIGNATURE Mary A Eline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River c. LENGTH OF STAY IN 1b 54 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River d. STREET ADDRESS 3 Forest Rd. (Forrest Rd.) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle W. Last Pritchett				4. DATE OF DEATH Month Jan. Day 7, Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 26, 1926	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 30 Days 30		IF UNDER 24 HRS. Hours 30 Min. 30			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer				10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? Balto. Md.							
13. FATHER'S NAME Albert Pritchett				14. MOTHER'S MAIDEN NAME Margaret Loos			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 215-22-4230		17. INFORMANT Address Diana V. Pritchett, 3 Forrest Rd. Balto. Md. 20			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr. NAME (Type) William V. Lovitt, Jr., M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10/57		22c. NAME OF CEMETERY OR CREMATORY Philips Herwig Sons ADDRESS 2024 Orleans St. 31		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philips Herwig Sons				24a. REC'D BY REGISTRAR JAN 10 1957		24b. REGISTRAR'S SIGNATURE Edith Harleys	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the undersigned. This certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Medical Examiner's Office along with form PM-3. Page 5 may be retained for the funeral director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 10 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

338

CERTIFICATE OF DEATH

00333

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>11 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood St. Tr. School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ershel</u> Middle <u>Carroll</u> Last <u>Randolph</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/33</u>	9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ershel Randolph</u>				14. MOTHER'S MAIDEN NAME <u>Ora Della Hussey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Rosewood Records</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia and</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>mentally defective, congestive pleuritis</u> DUE TO (c) <u>with epileptic fits.</u>							INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>August 4</u> , 19 <u>44</u> , to <u>January 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 23</u> , 19 <u>57</u> , and that death occurred at <u>7:10 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Dr. Rich. Lindenberg (P.L.S.)</u> M.D. <u>700 Fleet Street, Baltimore 2, Md. 1/24/57</u> PHYSICIAN'S NAME (Type) <u>Dr. Richard Lindenberg, Pathologist</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>BURIAL</u>	<u>JAN 25 57</u>	<u>Rosewood Cemetery</u>		<u>Owings Mills Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Flinn's Restorations</u>				ADDRESS <u>19d</u>		24a. REC'D BY REGISTRAR DATE <u>1-24-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>

BUREAU V. 3

JAN - 3 1957

RECEIVED

339

CERTIFICATE OF DEATH

Reg. Dist. No.

46

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Long Green Rd. Glen Arm</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Arm</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Julia Agnes Reier</u>		4. DATE OF DEATH Month Day Year <u>Jan. 1 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1883</u>
9. AGE (In years last birthday) <u>73</u> yn.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Dunleavy</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Mc Namee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. William Henry Reier,</u>		Address <u>Glen Arm, Md. Long Green Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>14 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2, 1943</u> to <u>Jan 1, 1957</u> , that I last saw the deceased alive on <u>Jan 1, 1957</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Fork, Md.</u>	
DATE SIGNED <u>1/2/57</u>			
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		<u>FORK, MD.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/5/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Long Green, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR <u>JAN 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 7 1957

RECEIVED

TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

211

00344

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		TOWN <u>BALTIMORE</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>		LENGTH OF STAY (in this place) <u>2 WEEKS</u>		STREET ADDRESS (if rural give location) <u>2421 CHRISTIAN ST.</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4618 LEEDS AVE</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna Margaret Scheffel</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 15 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT. 16, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE RIMBACH</u>				14. MOTHER'S MAIDEN NAME <u>WISKOW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>HARRY SCHEFFEL 2421 CHRISTIAN ST.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Atherosclerosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension, Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 14</u> , 19 <u>54</u> , to <u>Jan 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>57</u> , and that death occurred at <u>12:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Kathleen V. Krop</u>				ADDRESS (Street, city, town, state) <u>722 Stamper Rd Baltimore Md</u>		DATE SIGNED <u>1/16/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-18-57</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Heffers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George K. Schaub</u>		ADDRESS <u>2101 Frederick Ave</u>	
DATE <u>JAN 16 1957</u>							

RECEIVED

JAN 17

BUNTING & S

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00335

340

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COCKEYSVILLE</u>		LENGTH OF STAY (in this place) <u>15 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location) <u>1350 PATAPSCO</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM ALEXANDER RHEA</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 18 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9-7-1878</u>	9. AGE last birthday <u>78</u> YRS.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIP JOINER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>JOSEPH HENRY RHEA</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Spedden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Cockeysville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
18a. IMMEDIATE CAUSE (A) <u>Atherosclerotic Cardiac</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
18b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-2-1955</u> , to <u>1-18-1957</u> , that I last saw the deceased alive on <u>1-18-1957</u> , and that death occurred at <u>11:22 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter J. Keen</u>		M.D. <u>Cockeysville Md.</u>		DATE SIGNED <u>1/18/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN. 21, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. REC'D BY REGISTRAR DATE: <u>1957</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK, INC. 1217 ST. PAUL ST.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

RECEIVED

JAN 21 1957

1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 12 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00336

37

Reg. Dist. No.

341

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
TOWN <u>COCKEYSVILLE</u>		<u>9 YEARS</u>		<u>2619 MARYLAND AVE</u>		<u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LITA</u>		(Middle) <u>FRENCH</u>		(Last) <u>RHODES</u>		(Day) <u>28</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-6-1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELIPHAH FRENCH</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE LINCOLN MOWE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Cockeysville Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Cardio</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>						<u>6 MONTHS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-28, 1948</u> , to <u>1-28, 1957</u> , that I last saw the deceased alive on <u>1-28, 1957</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Keen</u>		M.D. <u>Cockeysville, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/28/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-31-57</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon PK</u>		LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
24. REC'D BY REGISTRAR <u>1-29-57</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook</u>		ADDRESS <u>146 1217 St Paul St</u>	

RECEIVED

JAN 7 1957

BUREAU V. S.

342

CERTIFICATE OF DEATH

0033738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>		d. STREET ADDRESS <u>201 Courtland ave</u>	
3. NAME OF DECEASED (Type or print) <u>LIDA</u> First <u>MAY</u> Middle <u>ROBINSON</u> Last		4. DATE OF DEATH <u>Jan 15</u> Month <u>15</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Keyes</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Coppersmith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mary E. Robinson</u> Address <u>201 Courtland ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arricular Fibrillation</u> DUE TO (c) <u>Arterio-sclerotic C-V disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>6 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 6</u> , 1957, to <u>Jan 13</u> , 1957, that I last saw the deceased alive on <u>Jan 15</u> , 1957, and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Tom H. Sedlack</u>		ADDRESS (Street, city or town, state) <u>200 W. Penna. Ave Towson 4.</u> DATE SIGNED <u>1/16/57</u>	
PHYSICIAN'S NAME (Type) <u>TOS. H. SEDLACK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 17, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Maria Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Gerbasi & Sons Co.</u> ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>12 1057</u> 24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 18 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G210, 2/4/57 bh

CERTIFICATE OF DEATH

00338

Reg. Dist. No.

343

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Cargil Ave.</u>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md.</u> d. STREET ADDRESS <u>1 Cargil Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Oscar C. Robinson</u> First Middle Last			4. DATE OF DEATH <u>January 24, 1957</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1907</u>		9. AGE (In years last birthday) <u>56</u> yrs IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tire Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md.</u>			
13. FATHER'S NAME <u>Howard Robinson</u>			14. MOTHER'S MAIDEN NAME <u>Laura Jones</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Sallie C. Robinson 1 Cargil Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>27 Oct 1956</u> , to <u>24 JAN 1957</u> , that I last saw the deceased alive on <u>24 JAN 1957</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. R. Davidson</u> M.D. <u>2112 W. North Ave.</u> PHYSICIAN'S NAME (Type) <u>Charles R. Davidson</u> <u>Baltimore 17, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>1631 Druid Hill Ave</u> <u>Holland Funeral Home</u>					
24a. REC'D BY REGISTRAR DATE <u>JAN 30 '57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JAN 20 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

344

CERTIFICATE OF DEATH

Reg. Dist. No.

00339

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines 16 Rusting Ave				d. STREET ADDRESS 4214 Connecticut Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Bessie Middle Pusey Last Rodgers				4. DATE OF DEATH Month Jan. Day 20 Year 1957			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 14, 1880	9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Amor Steele				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs Wilmer K. Gallagher, 429 Drury Lane.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 27 mo 10 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from July 8, 1934 , to Jan. 20, 1957 , that I last saw the deceased alive on Jan. 18, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilmer K. Gallagher				ADDRESS (Street, city or town, state) M.D. 6209 Frederick Road Baltimore 28, Md.		DATE SIGNED 1-22-57	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery Balto. Md.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke				ADDRESS 4101 Edmondson		24a. REC'D BY REGISTRAR DATE AN 24 '57	
				24b. REGISTRAR'S SIGNATURE W. H. Leach			

BUREAU V. S.

JAN 1 1907
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The third copy of this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use in burial transit permit.

VE AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00340

345 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>118 Oak Drive</u>				STREET ADDRESS (If rural give location) <u>118 Oak Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Albert August Molley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 5 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Feb. 19, 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Sirdan Rolfe</u>				14. MOTHER'S MAIDEN NAME <u>Catherine M. Rolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Marjorie Rolfe 118 Oak Drive</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>SUBACUTE (ACUTE) NEPHRITIS.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>SENILITY.</u>				<u>1 YEAR</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>0</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 2, 1957</u> to <u>Jan. 5, 1957</u> , that I last saw the deceased alive on <u>Jan. 5, 1957</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>6348 FREDERICK ROAD CATONSVILLE MD</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Jan 5 - 57</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Catonsville, Md.</u>	
DATE <u>Jan 18 57</u>							

BUREAU N. Y.

JAN 18 1957

RECEIVED

346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home of the Pines</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>1143 Sargeant St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>E.</u> Last <u>Rooney</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1957</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/1892</u>
9. AGE (in years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Bakery Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James F. Rooney</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Huster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. James F. Rooney</u>		Address <u>1025 W. Cross St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Small Intestine</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-21</u> , 19 <u>57</u> , to <u>1-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Urlocic Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1227 Wash. Blvd. Baltimore 1-4-57</u>	
PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCIC JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral C.</u>	22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>		24a. REC'D BY REGISTRAR <u>John J. Hollins</u>	
24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN

RECEIVED

347

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 N. Symington Ave</u>		d. STREET ADDRESS <u>31 N. Symington Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William John Ruehl</u>		4. DATE OF DEATH Month Day Year <u>Jan. 31, 19 57</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager, Sun Life Ins. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William F. Ruehl</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Jean O. Ruehl, 31 N. Symington Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/25</u> , 19 <u>42</u> , to <u>1/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>57</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eliot W. Johnson</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3432 Mellick Ave 1/31/57</u>	
PHYSICIAN'S NAME (Type) <u>ELIOT W. JOHNSON MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore 29, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witke</u>		ADDRESS <u>4101 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 4 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

FEB 4 1957

RECEIVED

348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF NELLIE First Middle Last		4. DATE OF DEATH JANUARY 5 19 57 Month Day Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 1, 1887	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED CAHALL		14. MOTHER'S MAIDEN NAME MARGARET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MR WILLIAM SANDERS Address 35 PATAPSCO RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DECOMPENSATORY HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR HEART DISEASE DUE TO (c) CENTRALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 15 , 19 52 to JANUARY 5 , 19 57 that I last saw the deceased alive on JANUARY 5 , 19 57 , and that death occurred at 1:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove St 1600 DATE SIGNED 1/5/1957			
ACTUAL SIGNATURE Bruno Radauskas M.D.		PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY Green Haven		22d. LOCATION (City, town, or county) (State) Green Haven, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Singleton ADDRESS Green Haven, Md.		24a. REC'D BY REGISTRAR Jan 8 57 24b. REGISTRAR'S SIGNATURE W. B. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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349

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 Register Ave.				d. STREET ADDRESS 6515 Maplewood Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Thomas Middle O. Last Schenkel				4. DATE OF DEATH Month Jan. Day 13, Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1882		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY R. R. Express		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Schenkel				14. MOTHER'S MAIDEN NAME Susan Riston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Frederick Jacob 6515 Maplewood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular DUE TO (c) Vascular Disease						INTERVAL BETWEEN ONSET AND DEATH 3 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct 2, 1946 to January, 1957 that I last saw the deceased alive on Jan 12, 1957 and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 2501 York Rd.		DATE SIGNED 1/15/57	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell				Tolson #4 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.				ADDRESS 715 Light St.		24a. REC'D BY REGISTRAR DATE JAN 15 1957	
				24b. REGISTRAR'S SIGNATURE Mabel Gray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

350

CERTIFICATE OF DEATH

Reg. Dist. No.

003462

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLERLEA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLERLEA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>4509 FORREST VIEW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THERESA M SCHNEIDER</u>				4. DATE OF DEATH Month Day Year <u>JAN 8 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 16-1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MICHAEL STICKENREUTHER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET KREIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
				17. INFORMANT <u>MARIE SCHEVE</u> Address <u>4509 FORREST VIEW AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Massive Myocardial Infarction</u> DUE TO Lying cause lost. (c) <u>Arterio-sclerotic Cardiovascular Disease</u> <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>30 seconds</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-16</u> , 195 <u>6</u> , to <u>1-8</u> , 195 <u>7</u> , that I last saw the deceased alive on <u>1-7</u> , 195 <u>7</u> , and that death occurred at <u>6:10</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul L. Mueller</u> M.D. <u>6331 Belair Rd Balto</u>				DATE SIGNED <u>1-9-57</u>			
PHYSICIAN'S NAME (Type) <u>PALL GODFREY MUELLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>HQCC BELAIR RD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bros</u> ADDRESS <u>210 BELAIR RD</u>				24a. REC'D BY REGISTRAR DATE <u>1-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Ruffenberger</u>	

BUREAU V. S.

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

351

CERTIFICATE OF DEATH

Reg. Dist. No.

00347

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Rd.</u>				d. STREET ADDRESS <u>Glenarm Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Sister Mary Carmel Schoder</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1867</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rochester, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Schoder</u>				14. MOTHER'S MAIDEN NAME <u>Anna Konrad</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Sister M. Peter Fourier</u>		Address <u>Notch Cliff, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>January</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Tues Jan. 22, 1957</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7521 York Road Towson 4, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Geiler</u> ADDRESS <u>901 S. CONKLING ST. BALTO. 24, MD.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>1-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Nabel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 27 1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

352 CERTIFICATE OF DEATH

00348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 8 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Route #2	
3. NAME OF DECEASED (Type or print) First NOAH Middle Last SCHOOLFIELD		4. DATE OF DEATH Month January Day 8 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Timbering	9. AGE (In years last birthday) yrs. 60
11. BIRTHPLACE (State or foreign country) Pocomoke City, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Schoolfield		14. MOTHER'S MAIDEN NAME Sadie Copes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, RIGHT 33/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE VASCULAR DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 31 1956 , to January 8 , 19 57 ; that death occurred at 9:05 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Irving Freeman M.D. VA HOSPITAL, FORT HOWARD, MARYLAND		1/9/57	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Ft. Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-11-57	22c. NAME OF CEMETERY OR CREMATORY St. James Meth. Church Cem.	22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Sam Savage Funeral Home, New Church, Va.		24a. REC'D BY REGISTRAR DATE 1/15/57	
24b. REGISTRAR'S SIGNATURE Lawson L. Lantry			

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JAN 16 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00349

353

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) iii. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr3mthl1dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1642 Light St. - Balto. 30			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Herman Middle E. Last Schroth				4. DATE OF DEATH Month January Day 10 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stevedore				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Schroth				14. MOTHER'S MAIDEN NAME Margaret Wingert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease							
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. 21, 1956 to Jan. 10, 1957 , that I last saw the deceased alive on Jan. 10, 1957 , and that death occurred at 1:15p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) DATE SIGNED 1-10-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Baltimore 25, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.				24a. REC'D BY REGISTRAR DATE Jan 14 57		24b. REGISTRAR'S SIGNATURE Deborah	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Boward	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6114 Rich Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMEY Middle EDNAR Last SCOTT		4. DATE OF DEATH Month January Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1891
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min 15	11. IF UNDER 24 HRS Months 6 Days 15 Hours 15 Min 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Duties		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Barnes		14. MOTHER'S MAIDEN NAME Annie Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 220-30-6351	
17. INFORMANT Mrs. Anna Foreman		Address 38 A Winters Avenue Catonsville 28, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma - Peritoneum DUE TO adenocarcinoma - Liver DUE TO adenocarcinoma - Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Arterio-sclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 20, 1955 to Jan. 15, 1956 , that I last saw the deceased alive on January 15, 1957 , and that death occurred at M. , from the causes and on the date stated above. For The Johns Hopkins Hospital ADDRESS (Street, city or town, state) 601 N. Broadway, Baltimore 5, Md. DATE SIGNED 1/17/57			
ACTUAL SIGNATURE HARRY L. CHANT, M. D. PHYSICIAN'S NAME (Type)		ASSISTANT DIRECTOR, THE JOHNS HOPKINS HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/18/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR JAN 21 57	24b. REGISTRAR'S SIGNATURE W. H. Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

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JAN 21 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0035138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MASS. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 2 WKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1705 EDGEWOOD RD. APT. D		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILFORD	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN VINCENT SENNOTT		4. DATE OF DEATH Month Day Year JAN 12 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME GEORGE N. SENNOTT		14. MOTHER'S MAIDEN NAME CAREY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 018-05-0339	
17. INFORMANT GEORGE SENNOTT Address 1705 EDGEWOOD RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 YRS.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/57	
22c. NAME OF CEMETERY OR CREMATORY St Mary's Cem.		22d. LOCATION (City, town, or county) (State) Milford Mass	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Conner ADDRESS Baltimore - Md.		24a. REC'D BY REGISTRAR JAN 15 1957	
		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 1 1951
BUREAU V. S.

356
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>206 Oak Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Webster</u> Last <u>Shipley</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpentier</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Arthur A. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Nina E. Stocksdales</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>212-01-5396</u>	
17. INFORMANT <u>Mrs. Nina E. Shipley</u>		Address <u>206 Oak Ave., Pikesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis - 8 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1949</u> to <u>Jan 31st 1957</u> , that I last saw the deceased alive on <u>Jan 30th 1957</u> , and that death occurred at <u>10:42 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller, M.D.</u>		ADDRESS (Street, city or town, state) <u>Pikesville - Md.</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>		DATE SIGNED <u>2/1/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Smith, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>1 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 7 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00353

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 84 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 33 Hanover Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Shugars Last Shugars		4. DATE OF DEATH Month Jan. Day 24 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1872
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Shugars		14. MOTHER'S MAIDEN NAME Julia Yingling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. J. Selman Biehl, Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.-V. Disease 7221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from Feb. 21, 1957 , to Jan. 24, 1957 , that I last saw the deceased alive on Jan. 23, 1957 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd., Reisterstown, Md. DATE SIGNED 1-25-57			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd., Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 27, 57	
22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons Reisterstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR 1-24-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

00354

358

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9: 1-11-57 et

1. PLACE OF DEATH- COUNTY <u>Baltimore,</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville,</u> TOWN <u>Catonsville,</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in The Pines 16 Rusting Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>5413 Penbrooke Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>William C. Skinner</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>2,</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 24, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lawyer</u>	9. AGE last birthday <u>85</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Truman Skinner</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Constable</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Ruth Fowers 5413 Penbrooke Ave.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4- Immediate cause (a) Acute Myocardial Decompensation

Antecedent cause(s) (b) Chronic Hypertensive Cardio-Vascular Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

1 day10 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-20, 1956, to 1-2, 1957, that I last saw the deceased alive on 1-1, 1957, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 4, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>John O. Mitchell & Sons Inc. 1900 Futaw Pl.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

359

CERTIFICATE OF DEATH

00355

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Byway Road		d. STREET ADDRESS Byway Road	
3. NAME OF DECEASED (Type or print) First Annie Middle I. Last Smith		4. DATE OF DEATH Month Jan. Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1885
9. AGE (In years and birthday) 71 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Wolfenden		14. MOTHER'S MAIDEN NAME Charlotte Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 6065 Falls Rd. Baltimore 9k Md.	
17. INFORMANT Mrs. Helen Foster		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 11.20.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260x (b) Arteriosclerotic C-V Disease DUE TO (c) 260x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 9 mos. 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none	
20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) none		20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none		(County) (State)	
21. I certify that I attended the deceased from Apr. 9 , 19 56 , to Jan. 24 , 19 57 , that I last saw the deceased alive on Jan. 18 , 19 57 , and that death occurred at 2 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE D. D. Caples		ADDRESS (Street, city or town, state) 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M.D.		DATE SIGNED 1-25-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-57	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seitz ADDRESS 814 W. 36th St., Balto., Md.		24a. REC'D BY REGISTRAR Jan 25 1957 24b. REGISTRAR'S SIGNATURE Mary Eline	

BUREAU V. S.

JAN 03 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

360

CERTIFICATE OF DEATH

Reg. Dist. No.

003561

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 7				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Baltimore - 7			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5604 Gwynn Oak Ave.				e. STREET ADDRESS 5604 Gwynn Oak Ave.			
3. NAME OF DECEASED (Type or print) First IMOGENE Middle C. Last SMITH				4. DATE OF DEATH Month Jan. Day 17 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1901	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Zellers			14. MOTHER'S MAIDEN NAME Anna J. Dooley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Pauline Collins - 5604 Gwynn Oak Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease & M.S. + I 41 X DUE TO acute S. + I., ataxial fibrillation. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 5-24 , 19 49 , to 1-17 , 19 57 , that I last saw the deceased alive on 1-15-57 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon Ashman		M.D. 5907 Gwynn Oak Ave		ADDRESS (Street, city or town, state) Balto. 7, Md		DATE SIGNED 1-18-57	
PRINTED NAME (Type) LEON ASHMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/21/57	22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17th			ADDRESS Balto. 17th		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Dr. J. M. Martin	

BUREAU V. S.

JAN 1907

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361

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>134 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waver Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>204 Tower Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALVIN</u> <u>(NM)</u> <u>SMITH</u>				4. DATE OF DEATH Month Day Year <u>January</u> <u>11</u> <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1907</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIDNEY R. SMITH</u>				14. MOTHER'S MAIDEN NAME <u>MARY R. RANKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>I</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Clin. Rec. Vets Admin. Hospital, Fort Howard, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RIGHT TONSIL</u> <u>145X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHO-PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>210 H</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 30</u> , 19 <u>56</u> , to <u>January 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 11, 1957</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u> DATE SIGNED <u>1/11/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>D. D. M. M. D.</u> <u>Fort Howard, Pa.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Heavenly Rest Memorial Park, Hanover Co., Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Law</u> ADDRESS <u>802 N. Edison Ave., Baltimore</u>				24a. REC'D BY REGISTRAR DATE <u>Jan 15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Fawcett</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 17

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

362

CERTIFICATE OF DEATH

00358

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 10 yrs.				d. STREET ADDRESS 1811 W. 10th St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Silver Cross Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Snyder				4. DATE OF DEATH Month Jan. Day 26 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1870		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Snyder				14. MOTHER'S MAIDEN NAME Mary Jane Ogier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Rosalind Snyder, 4632 Schenley Rd., Balto. 10, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Naso-pharyngitis & Bronchitis DUE TO (c) none						INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy & Mixed tumor of parotid gland						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 6-7-50 , 19____, to 1-26-57 , 19____, that I last saw the deceased alive on 1-25-57 , 19____, and that death occurred at 6 A. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 1-26-57							
ACTUAL SIGNATURE D. D. Caples M.D.				PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR JAN 28 1957		24b. REGISTRAR'S SIGNATURE Mary Elise	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 2 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>34th</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE BALTO CO MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON-RIDGER NURSING</u>		d. STREET ADDRESS <u>1226 N BRADFORD</u> IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH G. SOWERS</u>		4. DATE OF DEATH <u>1/30/57</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. HOFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATH. DETTERMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>EDWARD SOWERS</u>	
17. INFORMANT <u>EDWARD SOWERS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>447X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Approx 10yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/30</u> , 19 <u>56</u> , to <u>1/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/19</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 Edmondson Ave</u> DATE SIGNED <u>1/31/57</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>4605 EDMONDSON AVE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>	22d. LOCATION (City, town, or county) (State) <u>RITCHIE HEIGHTS, BALTO CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. FAHNEY</u> ADDRESS <u>1318 LEE ST</u>		24a. RECEIVED BY REGISTRAR <u>1/31/57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BUREAU V. S.

1057 4 3

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>	
c. LENGTH OF STAY IN 1b <u>7 mo.</u>		d. STREET ADDRESS <u>1129 H. Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1129 H. St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Elizabeth</u> Last <u>Spicer</u>		4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas J. Higgs</u>		14. MOTHER'S MAIDEN NAME <u>Carolina Croft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>	
17. INFORMANT <u>Ollie Dietrich</u>		Address <u>1129 H. St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>171X</u> <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Cervix</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1956</u> , to <u>June 11, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>5:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Means</u>		ADDRESS (Street, city or town, state) <u>520 D St. Balto. Md.</u>	
PHYSICIAN'S NAME (Type) <u>James T. Means</u>		DATE SIGNED <u>1/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shenandoah E. U. Church</u>	22d. LOCATION (City, town, or county) (State) <u>Shenandoah Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Ambrose, Jr.</u>		ADDRESS <u>1328 Sulphur Sp. Rd.</u>	
24a. REC'D BY REGISTRAR <u>151057</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANAU V. S.

JAN 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o. STATE Ma. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5552 Ashbourne Rd.		d. STREET ADDRESS 5552 Ashbourne Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Carl Harrison Spurrier		4. DATE OF DEATH Month Day Year Jan. 8/57 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1890
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Spurrier		14. MOTHER'S MAIDEN NAME Laura Beall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Clara M. Spurrier		Address 5552 Ashbourne Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Advanced Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Liver cirrhosis			INTERVAL BETWEEN ONSET AND DEATH 5 yrs 8 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1955 , to Jan 8, 1957 , that I last saw the deceased alive on Jan 8, 1957 , and that death occurred at 9:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Justinas Kudirka		ADDRESS (Street, city or town, state) DATE SIGNED 2151 Wilkes Ave Balt., 1.10.57	
PHYSICIAN'S NAME (Type) J. Kudirka		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 12/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Balt. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Witke		ADDRESS 4101 Edmondson Ave.	
24a. REC'D BY REGISTRAR 1 1957		24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Zupfers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. S.

AN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

201

CERTIFICATE OF DEATH

00362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore 22</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>as</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	c. LENGTH OF STAY IN 1b <u>25 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>in</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7526 New Battle Shore Circle</u>		d. STREET ADDRESS <u># 1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE CLARA SRAMEK</u>		4. DATE OF DEATH Month Day Year <u>JAN 1 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Bohemia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>James Kazda</u>		14. MOTHER'S MAIDEN NAME <u>Anna (last unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT Name Address <u>Charles Schramet (in # 1)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial failure</u> <u>44</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular disease</u> (c) <u>Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture both bones of right wrist Dec 10/56</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>not contributory to death</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>54</u> to <u>Nov 1</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Dec 29</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) <u>6908 N. Point Rd</u> DATE SIGNED <u>1/1/57</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>		<u>Balto - 19 - Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, 2601 E. Madison St.</u>		24a. REC'D BY REGISTRAR DATE <u>1/1/57</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 4 1957

BUREAU OF

365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>111 Birchwood Rd.</u>				d. STREET ADDRESS <u>111 Birchwood Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick Joseph Steas</u>				4. DATE OF DEATH Month Day Year <u>Jan 3 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1875</u>	9. AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metallurgist Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>reass & retail</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Pa.</u>	
13. FATHER'S NAME <u>Wilhelm Steas</u>				14. MOTHER'S MAIDEN NAME <u>Mary ---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. John Tussing 111 Birchwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompenstation</u> <u>445A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Ch. Hypertensive Cardio-Vascular Disease</u> DUE TO (b) <u>?</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left Hip 11/28/56 - not a contributing factor</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>---</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tripped on rug at home</u>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>11-28</u> , 19 <u>56</u> , to <u>1-3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>57</u> , and that death occurred at <u>1:50 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>62022ndrich Rd Catonsville 28 1-4-57</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>---</u>		22b. DATE THEREOF <u>1-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fisher Funeral Home - Catonsville, Md.</u>				ADDRESS <u>---</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 8 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

BUREAU V. S.

AN 8 1957

RECEIVED

366

CERTIFICATE OF DEATH

00364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OWEN R. STAGMER</u>		4. DATE OF DEATH <u>11/29/57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/1903</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drug store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacy</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eugene Stagner</u>		14. MOTHER'S MAIDEN NAME <u>Heidy Stagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Emma Stagner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio-Sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4-5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan-22</u> , 19 <u>57</u> , to <u>Jan-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan-29</u> , 19 <u>57</u> , and that death occurred at <u>7:15</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Lloyd Johnson</u> M.D.		DATE SIGNED <u>Catonville, MD</u>	
PHYSICIAN'S NAME (Type) <u>S. Lloyd Johnson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/1/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) <u>Towson MD</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Johnson</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>4</u> DATE <u>1/4/57</u>	24b. REGISTRAR'S SIGNATURE <u>Antwail</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

7 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00365

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2402 Manning Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence E Stark				4. DATE OF DEATH Month 1-11-57 Day Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1894	
9. AGE (in years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Koppers Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonn Stark				14. MOTHER'S MAIDEN NAME Ann Bittinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Alma G. Stark, Address 2402 Manning Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis, M.D.				DATE SIGNED 1/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-14-57		22c. NAME OF CEMETERY OR CREMATORY Bittinger Cemetery		22d. LOCATION (City, town, or county) (State) Bittinger, Md. (Garrett Co)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR JAN 14 1957 24b. REGISTRAR'S SIGNATURE Lawsford Larkins			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1967

RECEIVED

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 Yr. 1 Mo. 14 Das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard & Enoch Pratt Hosp. Towson 4, Maryland		d. STREET ADDRESS 4301 Massachusetts Ave., N. W.	
3. NAME OF DECEASED (Type or print) First Ruth Middle Service Last Stidham		4. DATE OF DEATH Month January Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1906
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Tire Business	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert J. Service		14. MOTHER'S MAIDEN NAME Laura Lindeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Endocarditis 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Fever DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 yr 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anxiety Reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 9, 1955 to Jan 23, 1957 , that I last saw the deceased alive on Jan 22, 1957 , and that death occurred at 8:43 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. W. Elgin		M.D. Towson - 4, Md DATE SIGNED 1/23/57	
PHYSICIAN'S NAME (Type) William W. Elgin, M. D.		Sheppard-Pratt Hospital, Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 25, 1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Lesdars Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Lewis Sons Co - 300 - 4th St. N. W.		24. REG'D BY REGISTRAR 1/25/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Mabel Gray	

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1957

RECEIVED

369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>NEW YORK</u> N. Y. b. COUNTY <u>V</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City.</u>	
		d. STREET ADDRESS <u>200 E. 66th. Street</u>	
		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wilson Breckenridge Stringer</u>		4. DATE OF DEATH Month Day Year <u>Jan 1 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contracting Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cockeysville, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>MDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas C. Stringer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Haughy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Howard C. Marchant</u>		Address <u>222 Oakdale Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary fibrosis + infection</u> <u>526x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiectasis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Jan 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 28</u> , 19 <u>56</u> , and that death occurred at <u>9:20 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Crawford N. Kirkpatrick Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>6 E. Eager St., Baltimore 2, Md.</u>	
PHYSICIAN'S NAME (Type) <u>CRAWFORD N. KIRKPATRICK, JR., M.D.</u>		DATE SIGNED <u>Jan 2, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reisterstown Methodist Church Cemetery, Reisterstown, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. T. ...</u>		ADDRESS <u>Calvert Street</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 4 '57</u>		24b. REGISTRAR'S SIGNATURE <u>C. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IAN 4 1957

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370

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2805 Alden Rd.</u>		d. STREET ADDRESS <u>12805 Alden Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Grete Margaret Strobel</u>		First Middle Last		4. DATE OF DEATH <u>Jan.</u> Month <u>12</u> Day Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1904</u>	9. AGE (In years last birthday) <u>52</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Hans Schmitt</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-36-4607</u>		17. INFORMANT <u>Mr. William K. Strobel</u> Address <u>2805 Alden Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V.D.</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>1/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/12/57</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>H. A. G. BOTT, M.D.</u>		M.D. <u>8100 Harford Rd.</u>			
PHYSICIAN'S NAME (Type) <u>H. A. G. BOTT, M.D.</u>		<u>Belt 14, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE <u>Dr. R. M. Bacon</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

371

CERTIFICATE OF DEATH

0036931

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - LIBERTY GARDEN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - LIBERTY GARDEN</u>			
c. LENGTH OF STAY IN 1b <u>7 YEARS</u>				d. STREET ADDRESS <u>13439 LIBERTY GARDEN RD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3439 LIBERTY GARDEN RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Alphonse</u> Last <u>Stromberg</u>				4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 7, 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>CARPENTER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HENRY STROMBERG</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE STEVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-05-8500</u>		17. INFORMANT <u>WIFE - ADA B. STROMBERG</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>5 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/25, 1955</u> to <u>1/18, 1957</u> that I last saw the deceased alive on <u>1/17, 1957</u> , and that death occurred at <u>530 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin G. Purpurt, M.D.</u>				ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD., BALTO., MD.</u>			
PHYSICIAN'S NAME (Type) <u>Edwin G. Purpurt, M.D.</u>				DATE SIGNED <u>1/18/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Strong</u> ADDRESS <u>3707 W. North Ave</u>				24a. REC'D BY REGISTRAR <u>DATE 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Martin</u>	

RECEIVED

JAN 21 1957

STAN V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK-22</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Baltimore 22</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>7839 St. Gregory's Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First Middle Last <u>Sudbrink</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12/1932</u>
9. AGE (in years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min. <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper Opn Mach</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel Corp</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>Baltimore</u>	
13. FATHER'S NAME <u>J. William Sudbrink</u>		14. MOTHER'S MAIDEN NAME <u>Frances Marvel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>219-28-0011</u>	
17. INFORMANT <u>Mrs. Sudbrink</u>		Address <u>125 Bayside Dr Baltimore</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING -</u> <u>129.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL THRU ICE IN BEAR CREEK OR INVERNESS-2</u>	
20c. TIME OF INJURY Month, Day, Year <u>1/19/57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>near creek</u>		20f. (City or town) (County) (State) <u>NW DUNDALK-22 Baltimore</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Mem. Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip's Herwig Sons</u>		24a. REC'D BY REGISTRAR <u>DATE 2/3/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Thm. Kelly</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Medical Director prior to burial, cremation, or removal.

RECEIVED
JAN 28 1957
BUREAU V. S.

372

CERTIFICATE OF DEATH

Reg. Dist. No.

7. PLACE OF DEATH o COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>64 N PROSPECT AVE</u>				d. STREET ADDRESS <u>1 64 N PROSPECT AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>E.</u> Last <u>SUSSMAN</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>18</u> Year <u>19-57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 4 16, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>CLARK</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dr. Sussman - 1470 Prospect Ave., 78</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive CVD</u> (c) <u>Senility, malnutrition</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>14 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 28</u> , 19 <u>55</u> , to <u>Jan 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>56</u> , and that death occurred at <u>11:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen Lee Nagness</u> M.D.				ADDRESS (Street, city or town, state) <u>908 Frederick Rd Catonsville, Md</u>			
DATE SIGNED <u>1-19-57</u>							
PHYSICIAN'S NAME (Type) <u>STEPHEN LEE NAGNESS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>1-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Thomas Home</u>				ADDRESS <u>Crown Point, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 28 1957
BUREAU V. S.

373
CERTIFICATE OF DEATH

Reg. Dist. No. 37

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth3dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Maryland	
d. STREET ADDRESS 20 Brightside Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Edna M. Talbert		4. DATE OF DEATH Month Day Year January 25, 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1895
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Theodore Shaffer		14. MOTHER'S MAIDEN NAME Ellen Shaffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 23, 19 57, to Jan. 25, 19 57, that I last saw the deceased alive on Jan. 25, 19 57, and that death occurred at 10:05 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 1-25-57			
ACTUAL SIGNATURE Stella Wachslar, M. D.		PHYSICIAN'S NAME (Type) Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-57	
22c. NAME OF CEMETERY OR CREMATORY Hampstead		22d. LOCATION (City, town, or county) (State) Cecil Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton		ADDRESS Hampstead Md	
24a. REC'D BY REGISTRAR DATE JAN 29 57		24b. REGISTRAR'S SIGNATURE Raymond	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AN 1057

FILED V. S.

1
 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

374

CERTIFICATE OF DEATH

00373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yr5mth8dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS North Avenue 5313/Edmondson Avenue	
3. NAME OF DECEASED (Type or print) First Lorentze Middle Taraldsen Last		4. DATE OF DEATH Month January 2, Day 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1867
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Oslo, Norway		12. CITIZEN OF WHAT COUNTRY? Norway ✓	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown --		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mr. Earle Taraldsen - Calchester Hall, Scarsdale,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1953 to Jan. 2, 1957 that I last saw the deceased alive on Jan. 2, 1957 , and that death occurred at 11:00p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Stella Wachslar M.D.		SPRING GROVE STATE HOSPITAL 1-2-57	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Queens, New York	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

72 5 13
1972

CERTIFICATE OF DEATH

Reg. Dist. No.

444

BUREAU V. C.

JAN 16 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00375

376 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Towson</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR STREET ADDRESS <u>Stella Marie Hospice</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>ROSE</u> (Middle) <u>TRAGESER</u> (Last)		(Month) (Day) (Year)	
		<u>1-11-57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 26 1865</u>
		9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months Days
		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Wilhelm Sommers</u>		14. MOTHER'S MAIDEN NAME <u>S</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>John Trageser 1719 Corsuch Ave</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Renal</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular Disease</u>		<u>10 yrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 19 55</u> to <u>Jan 11 57</u> , that I last saw the deceased alive on <u>Jan 11 57</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city, town, state) <u>1111/57</u>	
DATE SIGNED <u>1/11/57</u>			
23. BURIAL, CREMATON, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>Jan 14 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) <u>Baltimore Md</u>
24. REC'D BY REGISTRAR <u>1/15/57</u>	REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Jenkins</u>	ADDRESS <u>2713 Kirk Ave</u>

RECEIVED

JAN 16 1957

BUREAU W. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00376

Reg. Dist. No.

29

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton, (rural)</u>		c. LENGTH OF STAY IN TB <u>14 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton, (rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Corbett</u>				d. STREET ADDRESS <u>Corbett</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Henrietta Treadway</u> First Middle Last				4. DATE OF DEATH <u>Jan. 15</u> 19 <u>57</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice Dapprich</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Nau</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Amelia A. Treadway, Monkton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>76 17 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/15/57</u>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns (Waverley)</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>				ADDRESS <u>622 York Rd., Towson 4, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 21 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Eliz. G. Gouch</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute by certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 103. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 21 1957

BUREAU Y. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00377

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. (If institution: Residence before admission) a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto 84		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9415 Old Harford Road		d. STREET ADDRESS 9418 Old Harford Rd Balto	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Leroy Trout		4. DATE OF DEATH Month Day Year Jan 8 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1907
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Bethlehem Steel Co		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Glen Le Roy Trout		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-0355	
17. INFORMANT Mrs. Grace E. Trout, 9418 Old Harford		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4 1 DUE TO Chronic Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO Atherosclerosis moderately severe (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 8 yrs 7 undet	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 1-9-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Dr. A. M. Becons	
DATE 1-11-1957			

BUREAU V. 8

JAN 10 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00378

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 Old North Point Road</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1501 N. Patterson Park</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>E. ULLRICH</u> Last <u>ULLRICH</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1957</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29, 1894</u>		9. AGE (In years last birthday) <u>62</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Anton Neuman</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Doyas</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jerome W. Ullrich, son, 4205 Sheldon Ave.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> DUE TO <u>Ruptured Congenital Aneurysm of Left Middle Cerebral Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> <td> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> DUE TO <u>Ruptured Congenital Aneurysm of Left Middle Cerebral Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> DUE TO <u>Ruptured Congenital Aneurysm of Left Middle Cerebral Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>													
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1/30/57</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> <u>3331 Brehms Lane</u>				24a. REC'D BY REGISTRAR <u>FEB 1 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

FEB 1 1967

RECEIVED

203

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3004 DUNLEER RD</u>				d. STREET ADDRESS <u>3004 DUNLEER RD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOMER MERLE VARNER SR.</u>				4. DATE OF DEATH Month Day Year <u>JAN. 1. 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 16, 1900</u>	9. AGE (In years last birthday) <u>56</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELEVATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAIAH VARNER</u>				14. MOTHER'S MAIDEN NAME <u>ADA NOON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-10-9655</u>		17. INFORMANT Address <u>MINNIE S. VARNER - SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular-Renal Disease</u> DUE TO (c) <u>15 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1955</u> to <u>Jan. 1, 1957</u> , that I last saw the deceased alive on <u>December 31, 1956</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Owens</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>914 D St. Sparrows Point, Md. 1/1/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bradley Funeral Home 100 Yellow Springs Rd. Dundalk, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Jan 1</u>		24b. REGISTRAR'S SIGNATURE <u>mi</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1957

RECEIVED

380

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson #4		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Aigburth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle JAMES Last VELIE		4. DATE OF DEATH Month January Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1893.
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months 6 Days 15 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James B. Velie		14. MOTHER'S MAIDEN NAME Adeline White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Zenith H. Velie		Address 14 Aigburth Road Towson 4, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 yrs. (c) 6 mos.			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to January 1957 that I last saw the deceased alive on January 29, 1957 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd Towson #4 Md DATE SIGNED 1/31/57			
ACTUAL SIGNATURE Charles F O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F O'Donnell M.D. Towson #4 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 1, 1957.	22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR FEB 4 1957	
24b. REGISTRAR'S SIGNATURE Matel Gray			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 4 1957

RECEIVED

381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN Ib 8yr 6mth 1dy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilhelmina Middle Vogt Last Vogt		4. DATE OF DEATH Month January Day 30 , Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1884
9. AGE (In years last birthday) yrs 72		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28, 1948 to Jan 30, 1957 , that I last saw the deceased alive on Jan. 30, 1957 , and that death occurred at 1:35 A.M. from the causes and on the date stated above. Jan. 30, 1957 ADDRESS (Street, city or town, state) Spring Grove ST. HOSPITAL, Catonsville, Md. DATE SIGNED Gertrude J. Fleischman M.D. ACTUAL SIGNATURE Gertrude J. FLEISCHMAN M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Reburied		22b. DATE THEREOF Feb. 6 '57	
22c. NAME OF CEMETERY OR CREMATORY Quakertown U. of Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Alfred		24a. REC'D BY REGISTRAR DATE FEB 8 '57	
24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

CB 1. 1. 1.

1921

382

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Court Rd. #131</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>H. W.</u> Middle <u>Paul</u> Last <u>Voigt</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Otto Voigt</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Whrenberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Geo. Voigt - Old Court Rd. #131</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary-Renal Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov. 13</u> , 19 <u>56</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 27</u> , 19 <u>57</u> , and that death occurred at <u>1:45 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George E. Shannon</u>				ADDRESS (Street, city or town, state) <u>820 Medical Arts Bldg.</u>			
DATE SIGNED <u> </u>							
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>				ADDRESS <u>4411 Windsor M. I. Rd.</u>		24. REC'D BY REGISTRAR <u> </u>	
25. REGISTRAR'S SIGNATURE <u>Dr. H. L. Martin</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4 1957

RECEIVED

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00382

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN COCKEYSVILLE		LENGTH OF STAY (In this place) 2 YEARS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MASONIC HOME				STREET ADDRESS (If rural give location) 2438 EDMONDSON AVE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) LENA (Middle) (Last) VOLZ				(Month) (Day) (Year) JAN 1 19 57			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH 9-12-1882	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME CONRAD FUNK				14. MOTHER'S MAIDEN NAME ANNIE E SCHNEIDMILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 216-03-1775 D		17. INFORMANT'S ADDRESS Frank L. Smith Jr. Cockeysville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Arterio-Sclerotic Cardio-vascular Disease				INTERVAL BETWEEN ONSET AND DEATH 2 years			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-3 , 19 55 , to 12-31 , 19 56 , that I last saw the deceased alive on 12-31 , 19 56 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.							
SIGNATURE Walter T. Lees				ADDRESS (Street, city, town, state) Cockeysville Md.		DATE SIGNED 1/1/57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/5/57		NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		LOCATION (City, town, or county) BALTIMORE MARYLAND.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC.		ADDRESS BALTIMORE MARYLAND.	
DATE JAN 5 '57							

BUREAU V. S.

JAN 5 1917

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		STATE <u>Md</u> COUNTY <u>Balto</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		OR TOWN		STREET ADDRESS (If rural give location)	
TOWN <u>Pikesville</u>		<u>2 yrs</u>		<u>Pikesville</u>		<u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Lucia M. Wagner</u>				<u>January 21</u> 19 <u>57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>M.</u>	<u>5/22/1903</u>	<u>53</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Balto</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John R. Brown</u>				<u>Ida Turnbull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>218-18-3234</u>		<u>Robert J. Wagner, 21 Mac Rd</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Uremia</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Cervical Carcinoma</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>metastasis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>3 days</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
		<u>Cervical Carcinoma with metastasis</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>57</u> , to <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 2</u> , 19 <u>57</u> , and that death occurred at <u>7:25</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Thomas C. White</u>				ADDRESS (Street, city, town, state) <u>111 W. Monument St</u>			
DATE SIGNED <u>1/4/57</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>1/5/57</u>		<u>St. Thomas Church</u>		<u>Balto</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1/8/57</u>		<u>Dorothy Penick</u>		<u>Forcing Pyers</u>		<u>5005 E. 7th</u>	
DATE							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. 1

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

00384

2411 N. Charles Street, Baltimore

385 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines</u>		STREET ADDRESS (If rural, give location) <u>R.D. 7 Box 167</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Harry</u> (Middle) <u>R.</u> (Last) <u>Walker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 25 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 7 1874</u>
9. AGE last birthday <u>82</u> yrs.		10. If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph B. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Eliz. W. Bushnell 51 W. 71 N.Y.C.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Pneumonia, bilateral basilar</u>					
Antecedent cause(s) (b) <u>Hypertension heart disease with old arterial vascular accident.</u>				1-2 years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Fracture of back</u>				2 months.	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/31, 1955, to 1/25, 1957, that I last saw the deceased alive on 1/25, 1957, and that death occurred at 11:55 P m., from the causes and on the date stated above.

SIGNATURE Elvis P. Gumbly M.D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>1/27/57</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	LOCATION (City, town, or county) <u>Clearfield Penna.</u>	(State)
DATE REC'D BY LOCAL REG. <u>JAN 29 '57</u>		REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	24. JUDICIAL DIRECTOR <u>Wm J. Tschner + Mrs. H. R. Ba</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 30 1957
BUREAU Y. B.

386

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>19 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>417 JEFFERSON AVE.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
3. NAME OF DECEASED (Type or print) <u>LELIA E. WALKER</u>		d. STREET ADDRESS <u>417 JEFFERSON AVE</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 30, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. BROWN</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA DERRECKS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212 327722</u>	
17. INFORMANT <u>Wm. WALKER</u>		Address <u>417 JEFFERSON AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, METASTATIC, GENERALIZED</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF BREAST</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>ONE YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 1956</u> to <u>JAN 29 1957</u> , that I last saw the deceased alive on <u>JAN 29 1957</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thaddeus P. Siwinski</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>17 W. PENNA. AVE, TOWSON, MD. 1/30/57</u>	
PHYSICIAN'S NAME (Type) <u>T. C. SIWINSKI</u>		M.D. <u>MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>2/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT REST</u>		22d. LOCATION (City, town, or county) (State) <u>TOWSON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. McCallahan</u>		ADDRESS <u>1701 McCallahan St. Balto. Md.</u>	
24a. REC'D BY REGISTRAR <u>31 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thaddeus P. Siwinski</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 31 1951

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00386

387

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		LENGTH OF STAY (in this place) <u>6 YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>		STREET ADDRESS (If rural give location) <u>2906 BRIGHTON ST.</u>					
3. NAME OF DECEASED (First) (Middle) (Last) <u>IRVINE SPURRIER WALLACE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 22 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>WIDOW</u>	8. DATE OF BIRTH <u>7/21/1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOSEPH SPURRIER</u>				14. MOTHER'S MAIDEN NAME <u>MARY C. ETCHISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith Jr. Cockeysville Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <u>Arterio-Sclerotic Carditis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u>						1 month	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/3</u> , 19 <u>51</u> , to <u>1/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/21/57</u> , 19 <u>57</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Hays</u>		M.D. <u>Cockeysville Md.</u>		DATE SIGNED <u>1/22/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-24-57</u>		NAME OF CEMETERY OR CREMATORY <u>Pine Grove Mt Airy Md</u>		LOCATION (City, town, or county) (State) <u>Paul St.</u>	
24. REC'D BY REGISTRAR <u>JAN 2 1957</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm C. Cook</u>		ADDRESS <u>1517 St Paul St.</u>	

BUREAU V. S.

1937

JAN

RECEIVED
JAN 10 1937
U.S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

003874

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
<u>JAMES HENRY WATKINS</u>		<u>1</u> <u>8</u> <u>1957</u>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<u>M</u>	<u>C</u>		<u>Aug. 13, 1903</u>
9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<u>53</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Laborer</u>			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Macklenburg, Va.</u>		<u>U.S. ?</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Plummer Watkins</u>		<u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
<u>Mrs. Elvora Watkins</u>		<u>1551 N. Simon St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
Hour a. m. p. m. <u>19</u>		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>Jan 12, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Mt. Auburn Cemetery</u>		<u>Baltimore</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>Joseph L. Kues</u>		<u>DATE 1/10/57</u>	
ADDRESS <u>2222 W. North Ave. Balto. Md.</u>		24b. REGISTRAR'S SIGNATURE	
		<u>Dawson L. Farley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00388

389

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u>		c. LENGTH OF STAY IN 1b <u>52 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>1714 Lakeside Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Ray</u> Last <u>WATSON</u>		4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/91</u>
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wharton B. Watson</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Douglas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO ---	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary sclerosis with recent obstruction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (b) <u>Old myocardial infarcts</u> DUE TO (c) <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, Imbecillity</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/5/56</u> , 19 <u>56</u> , to <u>2/4/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/4/57</u> , 19 <u>57</u> , and that death occurred at <u>2:15 P.</u> M., from the causes and on the date stated above. <u>Eugenio Barranco, M.D.</u> ADDRESS (Street, city or town, state) <u>Owings Mills, Md.</u> DATE SIGNED <u>1/4/57</u>			
ACTUAL SIGNATURE <u>Richard Lindenberg, Pathologist</u>		PHYSICIAN'S NAME (Type) <u>Richard Lindenberg, Pathologist</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Owings Mills Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Ellensons Rusttown Md</u>		24a. REC'D BY REGISTRAR DATE <u>1-7-58</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>			

BUREAU V. A.

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

390

CERTIFICATE OF DEATH

00389

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 4 Mc Cormick Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Caroline Carrie E Weinberger		4. DATE OF DEATH Jan 24/57 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 13 1868
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Geo Spangenberg		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Mildred Doyle Address 4 McCormick Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cardio Vascular Disease 90 yrs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1940 , to Jan 24, 1956 , that I last saw the deceased alive on Jan 22, 1956 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE D. J. Battaglia MD M.D. 5-829 Belair Rd. Baltimore, Md.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF January 28 /57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Baltimore Co
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Ullrich Funeral Home 4210 Belair Road		DATE 29 1957 Mrs. D. L. Ruffenberger	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

BUREAU V. S.

JAN 26 1957

100

391 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>Paradise Nursing Home</u> <u>Paradise & Altamont Aves.</u>				STREET ADDRESS (If rural give location) <u>104 Symington Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ETHEL E. WERNIG</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan.</u> <u>12</u> <u>19 57</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 26, 1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>England</u>	
13. FATHER'S NAME: <u>Henry Edwards</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Keats</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>N. Y. Joseph Netter 130 E. 67th St. New York</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Terminal Hypostatic Pneumonia</u>		<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Cerebral Thrombosis</u>		<u>10/9/54 ad</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>445X</u>		<u>12/26/56</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardio Vascular Disease & Hypertension</u>		<u>20 yrs</u>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/22, 1936, to 1/13, 1957 that I last saw the deceased alive on 1/12, 1957 and that death occurred at 2:00 AM, from the causes and on the date stated above.

SIGNATURE <u>E. W. Johnson</u>	ADDRESS <u>M. D. 3432 Frederick Ave.</u>	DATE SIGNED <u>4/14/57</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Jan. 15, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>
		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>1/15/57</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>William Cook, Inc.</u>	ADDRESS <u>1217 St. Paul Street</u>
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MARGIN RESERVED FOR BINDING

VS. A15—10

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 1 1964
BUREAU OF

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1715 E. Lombard St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stanley Middle Lee Last Wheeler		4. DATE OF DEATH Month 1 Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10 1916
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pumpman		10b. KIND OF BUSINESS OR INDUSTRY Booth Steel Co	
11. BIRTHPLACE (State or foreign country) Springfield Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Boaz Wheeler		14. MOTHER'S MAIDEN NAME Sally Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1715 E Lombard St	
17. INFORMANT Stanley E Wheeler		Address 1715 E Lombard St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 26 1957	
22c. NAME OF CEMETERY OR CREMATORY Palmer Cemetery		22d. LOCATION (City, town, or county) (State) Palmer Co Va	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. R. B. Davis		ADDRESS 1715 E Lombard St	
24a. REC'D BY REGISTRAR DATE 2/1/57		24b. REGISTRAR'S SIGNATURE Dawson L. Forkey	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 24 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 12 Filled in by 1/31/57 at

CERTIFICATE OF DEATH

01604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 11			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4yr 8mo 8 dys.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Burns Last White				4. DATE OF DEATH Month 1 Day 30 Year 1957			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-19-86	
9. AGE (In years last birthday) 70 1/2 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 47 y.o. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Jan. 30, 1957 , to Jan. 30, 1957 , that I last saw the deceased alive on Jan. 30, 1957 , and that death occurred at 11:45p M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslor M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 1-31-57			
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Embalmed		22b. DATE THEREOF Feb. 6, 57		22c. NAME OF CEMETERY OR CREMATORY Gr. of Mt. Hed. Inland		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS _____				24a. REC'D BY REGISTRAR DATE _____		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. S.

FEB 11 1977

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00392

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Foreston c. LENGTH OF STAY IN 1b 1 wk. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Road		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. city city c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V-1-4 d. STREET ADDRESS 2935 Westwood Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Harrison Last Wilhelm		4. DATE OF DEATH Month Jan. Day 16 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1885
9. AGE (In years less birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 1	IF UNDER 24 HRS Hours 1 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electric Conductor		10b. KIND OF BUSINESS OR INDUSTRY Car	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Wilhelm		14. MOTHER'S MAIDEN NAME Edith Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-1120	
17. INFORMANT Stanley Wilhelm		Address Severna Park Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Hypertensive C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angina Pectoris DUE TO (c) Angina Pectoris		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none (County) none (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Jan. 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Forest Cemetery		22d. LOCATION (City, town, or county) Balto. Co. Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edwin C. Tipton, Hampstead, Md.		ADDRESS Hampstead, Md.	
24a. REC'D BY REGISTRAR DATE 1-17-57		24b. REGISTRAR'S SIGNATURE Mary B. Ehlke	

RECEIVED

JAN 11 1957

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00393

33

Reg. Dist. No.

395

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Owings Mills</u>	<u>5 years</u>	TOWN <u>Owings Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Morrisway Road</u>		STREET ADDRESS (If rural give location) <u>Morrisway Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Edith Lord Wills</u>		<u>Jan 25 19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>April 1 1892</u>
			9. AGE last birthday <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Yox</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mitchell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>SS 215-18-2233</u>	
		17. INFORMANT & ADDRESS <u>S/Sgt. John A Dever USAF</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Decompensated Hypertensive C-V Disease</u>			<u>5 yrs.</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Nephritis</u>			<u>15 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Obesity</u>			<u>30 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH.			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> <u>none</u>	21f. HOW DID INJURY OCCUR? <u>none</u>	
22. I hereby certify that I attended the deceased from <u>July 3, 1938</u> , to <u>Jan. 25, 1957</u> , that I last saw the deceased alive on <u>Jan. 24, 1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>D. A. Expler</u>		ADDRESS (Street, city, town, state) <u>M.D. 6 Hanover Rd., Reisterstown, Md.</u>	
DATE <u>Jan 28 1957</u>		DATE SIGNED <u>1/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Jan 28 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>	LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Berryman + Sons Reisterstown, Md</u>	ADDRESS

BUREAU V. S.

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JAN 10 1901

00394

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

396 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>17409 Western Ave</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> OR TOWN <u>Beltsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17409 Western Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> OR TOWN <u>Beltsville</u> STREET ADDRESS (If rural, give location) <u>17409 Western Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Wayne S Wilt</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>Jan 29</u> (Month) (Day) (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>May 5, 1956</u>
9. AGE last birthday <u>8</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		10. BIRTHPLACE (State or foreign country) <u>Md</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elmer B. Wilt</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Laird</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Virus pneumonia</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/27, 1957, to 1/29, 1957, that I last saw the deceased alive on 1/28, 1957, and that death occurred at 2 m., from the causes and on the date stated above.

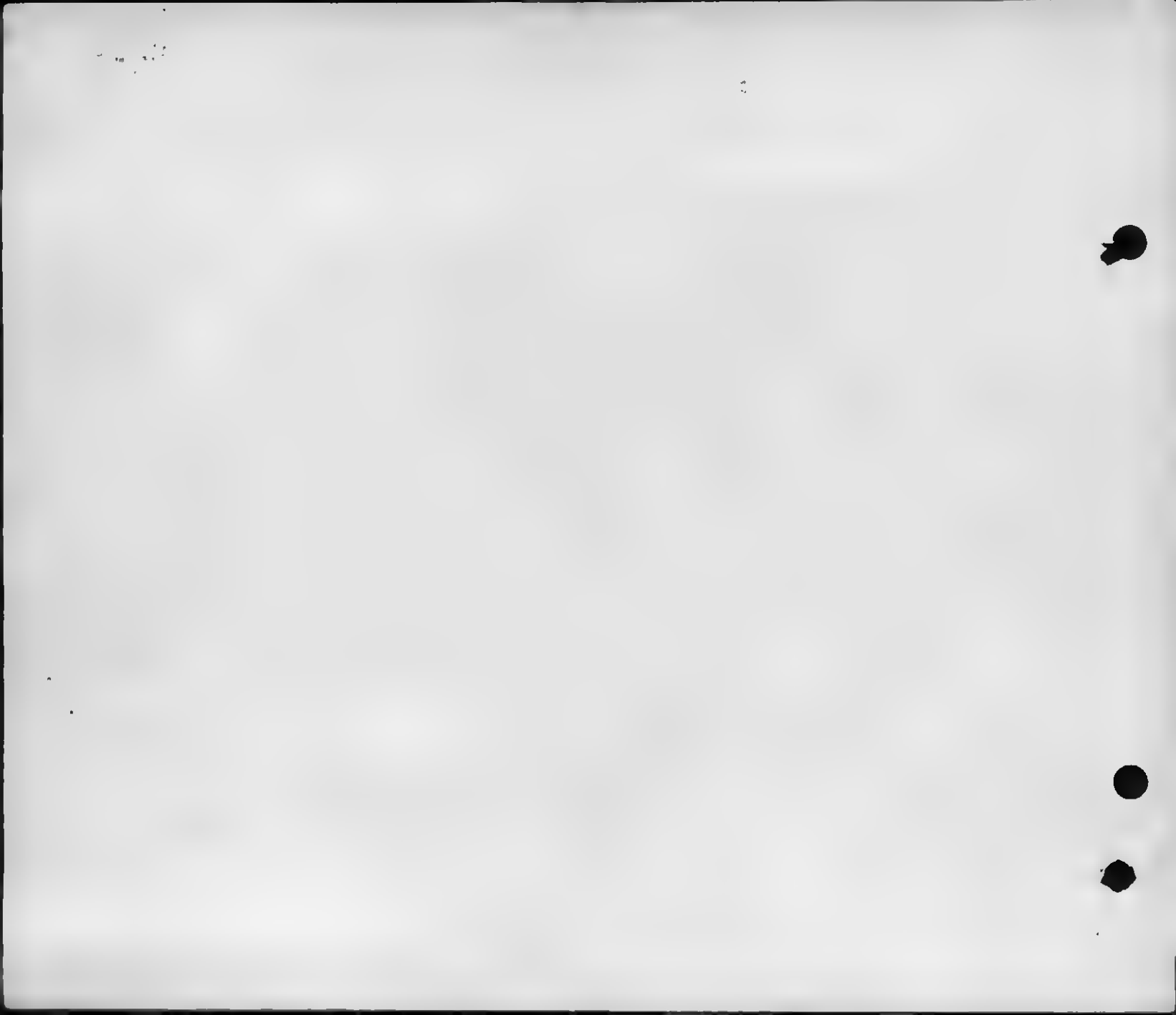
SIGNATURE Wm. L. Taylor (Degree or title) ADDRESS 840 Greenway Rd DATE SIGNED 1/30/57

23. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 12 1957</u>	<u>Morelands</u>	<u>Beltsville</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1-31-57</u>	<u>1-1-57</u>	<u>Edwin Geo & Son</u>	<u>1701-03 Patterson Park Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00395

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALT.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>Essex</u>			c. LENGTH OF STAY IN 1b <u>1 yr.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 268 Hollymead Rd.</u>			e. STREET ADDRESS <u>Box 268 Hollymead Rd.</u>		
3. NAME OF (Type or print) <u>Anthony J. Winkes</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-7-97</u>		9. AGE (In yrs. <u>59</u> <u>yr.</u>)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>	
13. FATHER'S NAME <u>Anthony J. Winkes</u>			14. MOTHER'S MAIDEN NAME <u>MARYA. COAKLEY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>YES WWI</u>		16. SOCIAL SECURITY NO. <u>25-24-2908</u>		17. INFORMANT <u>Stella Winkes</u> Address <u>5222 Harford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Syn</u> DUE TO (b) <u>Syn</u> (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>BALTO.</u>	(County) <u>MD</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-24-57</u>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Brundage</u>		ADDRESS <u>1407 Eastern Ave</u>		24a. REG'D BY REGISTRAR DATE <u>1-25-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Guth Hurley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give figures 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

398

CERTIFICATE OF DEATH

Reg. Dist. No.

00396

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Columbus	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 TIMONIUM ROAD		d. STREET ADDRESS 489 Northview Drive	
3. NAME OF DECEASED (Type or print) ROSE REBECCA WOLFE		4. DATE OF DEATH JAN 2 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1872
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Geiss		14. MOTHER'S MAIDEN NAME Julia Bier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 20, 1956 to JAN 2, 1957 , that I last saw the deceased alive on JAN 2, 1957 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Pillsbury		ADDRESS (Street, city or town, state) Timonium, Maryland	
PHYSICIAN'S NAME (Type) William A. Pillsbury M.D.		DATE SIGNED Jan. 3, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1957	
22c. NAME OF CEMETERY OR CREMATORY Forest Rose Cemetery		22d. LOCATION (City, town, or county) (State) Lancaster, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Stone		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR Jan. 3, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

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1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 412 Bulter Rd.	
3. NAME OF DECEASED (Type or print) First Martha Middle E. Last Ziegler		4. DATE OF DEATH Month January Day 11 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1869
9. AGE (in years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) hypertension (c) Pulmonary abscesses DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left femur			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) on 10-23-56 , patient allegedly slipped on floor and fell, sustaining fracture of left hip	
20c. TIME OF INJURY Month, Day, Year 4:00 a.m. 10-23-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville, 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>George M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-11-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/14/57	
22c. NAME OF CEMETERY OR CREMATORY LOUNSON PK		22d. LOCATION (City, town, or county) (State) FREDERICK AVE	
23. FUNERAL DIRECTOR'S SIGNATURE GEO LEIMBACH		ADDRESS 525 N LYNDAHURST ST	
24a. REC'D BY REGISTRAR JAN 14 57		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 14 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

400

CERTIFICATE OF DEATH

00398 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point			c. LENGTH OF STAY IN 1b 67 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point (Edgenere)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7403 North Point Road				d. STREET ADDRESS 7403 North Point Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle M. Last Kaloski (Zolosky)				4. DATE OF DEATH Month January Day 29 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Kordonski				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Clara Doerr Address 7405 North Point Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3 yrs 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 29, 1955 to Jan. 29, 1957 , that I last saw the deceased alive on Jan. 29, 1957 , and that death occurred at 4:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Means				ADDRESS (Street, city or town, state) 570 S. St. Balt. 19 Md DATE SIGNED 1/30/57			
PHYSICIAN'S NAME (Type) James T. Means							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street				24a. REC'D BY REGISTRAR FEB 1 1957		24b. REGISTRAR'S SIGNATURE Samson L. Farkas	

STATE OF DEATH

1. Name of deceased: [illegible] 2. Sex: [illegible] 3. Age: [illegible]

4. Date of death: [illegible] 5. Place of death: [illegible]

6. Cause of death: [illegible]

7. Signature of physician: [illegible]

8. Signature of registrar: [illegible]

9. Signature of informant: [illegible]

10. Signature of witness: [illegible]

11. Signature of witness: [illegible]

12. Signature of witness: [illegible]

13. Signature of witness: [illegible]

14. Signature of witness: [illegible]

15. Signature of witness: [illegible]

16. Signature of witness: [illegible]

17. Signature of witness: [illegible]

18. Signature of witness: [illegible]

19. Signature of witness: [illegible]

20. Signature of witness: [illegible]

21. Signature of witness: [illegible]

BUREAU V. 2

FEB 4 1957

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